

PSYCHOTHERAPY REFLECTIONS

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Thoughts about Psychotherapy

Gary Freedman

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Published by Gary Freedman / Lulu

ISBN 978-1-387-86294-8

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On the whole I have achieved what I wished to achieve. You shouldn't say it was not worth the effort. In any case, I don't want any human being's judgment. I only want to expand knowledge. I simply report. Even to you, esteemed gentlemen of the Academy, I have only made a report.

—Franz Kafka, A Report to an Academy

Introduction

I have written summaries of several clinical sessions I have had with my psychotherapist, a social worker. My therapist believes that my letters distort her work and that I present a biased view of her. Well, that is true. But my approach is valid and justifiable. My summaries of my therapy sessions are, in my view, an elaboration of a personal experience and not an ideologically objective portrait of my therapist.

My summaries are not and cannot be unbiased. In spite of the inescapable bias that is introduced in the process of a patient summarizing a therapy session, he still feels he has certain ethical obligations regarding how he portrays the therapist. My summaries are based on un-staged, un-manipulated actions. The editing is highly manipulative and the writing is highly manipulative. What I choose to write about, the way I write it, the way I edit it and the way I structure it – all of those things represent subjective choices that I have to make.

I only summarized a few sessions—near nothing. The compression within a sequence of innumerable interactions represents choice and then the way the sequences are arranged in relationship to the other represents choice. All aspects of summarizing a course of therapy represent choice and is therefore manipulative.

But the ethical aspect of it is that you have to try to make a report that is true to the spirit of your sense of what was going on. My view is that these summaries are biased, prejudiced, condensed, compressed but fair. I think what I do is write summaries that are not accurate in any objective sense, but accurate in the sense that I think they're a fair account of the experience I've had in doing therapy. I think I have an obligation to the therapist to summarize the sessions so that the letters fairly represent what I felt was going on at the time in the original sessions.

Autobiographical Note

The following text paraphrases, or adapts, Thomas Mann's introduction to Hermann Hesse's novel, Demian; as well as selected writings of Hesse in addition to the New Yorker article, "Hermann Hesse's Arrested Development" by Adam Kirsch.

If the truth be told I am not suited for the practicalities of life; my mind floats in otherworldly dreams, more preoccupied with the potential of the spirit than with everyday vicissitudes. I love language, books, and music, and the most splendid moments of my uneventful existence have been the few operas I have attended, or the books I have perused in isolation from my fellows. I treasure every detail of the times I have spent in isolation. As I read I imagine every sentence, every page and every chapter as a mirror of my life, my passions and my afflictions. I take refuge in this extravagant, romantic atmosphere whenever I feel weighed down by the vulgarity of life.

I am an artist, really. Or at least I am an individual with an artistic temperament. My moments of highest joy are those I have spent alone. And that is the triumph and tragedy of my existence. Despite the gratifications afforded by my splendid isolation I still long for the Other in my loneliness: the Other who might complete me. Failing to find that Other I live in perpetual disillusion and frustration.

I am a rebel individualist divorced from established dogma and institutions, a lonely incorrigible seeker of new norms. For me life presents itself as a struggle for individualism; I experience my life at times as humorously petulant and at other times as a mystically yearning estrangement from the world and the times. I sometimes feel, in my grandiose moments, that I belong to the highest and purest spiritual

aspirations and labors of our epoch.

My spiritual and emotional struggles can be traced to my alienation from my family in childhood. The roots of my estrangement from established institutions and settled norms began in the peculiarities of my early family life. Like most parents mine were no help with the new problems of puberty to which no reference was ever made. All they did was take endless trouble in supporting my hopeless attempts to deny reality and to continue dwelling in a childhood world that was becoming more and more unreal. I have no idea whether parents can be of help, and I do not blame mine. It was my own affair to come to terms with myself and to find my own way, and like most well-brought up children, I managed badly. My parents seemed wedded to some vague suggestions of old-world, Victorian morality with its belief in the inherent sinfulness of man, in the necessity of breaking the will of the individual, and with its uncompromising renunciation of all that is of this world. My family was the first of many social structures which were to rouse the rebel in me.

From a very young age, it was clear that there was a mismatch between me and my family. When it came to child-rearing, my parents' conviction in their rightfulness was evinced in a concerted effort to break my will, to teach me the docility and submissiveness that parental authority demanded.

I was an outsider in my family and I suffered the consequences of my defiance of my unforbearing father. Paternal beatings were my lot in childhood. Though I used to oppose such chastisement from the hands of my father with silent opposition, my little heart experienced them as unspeakably bitter, painful, and humiliating. My childhood was a tortured cycle of misbehavior, punishment, resentment, forgiveness, and renewed infractions.

Yet in me this moralistic force met an immovable object. I was the child of strict parents who made me aware from a very early age of the Fourth Commandment. Unfortunately, commandments have always had a catastrophic effect on me. Compelled to honor my father and mother, I instinctively refused. In jest, my father contemplated sending me away to an institution or to be raised by another family.

But in rebelling against my upbringing, I ended up recapitulating its central themes: I never lost the habit of rigorous self-examination or my feelings of unworthiness and my longing for an experience of a transcendent moment. I was a sensitive child, a gifted misfit who rejected my family, its rigorous demands, and its aspirations, and set out to discover the truth for myself. School held as little attraction for me as it did for any incorrigible. Hardly had the fourth year of high school begun before I became delinquent and was almost dismissed. I had created a negative identity for myself. I needed to find and defend a niche of my own against the excessive ideals demanded by my morbidly ambitious parents. My choice was dictated by a set of conditions in which it was easier for me to derive a sense of identity out of a total identification with that which I was least supposed to be than to struggle for a feeling of reality in acceptable roles, which, for me, represented spiritual death.

I have spent my adult life determined to not accept the dictates of any authority by behaving in opposition to it. I rebel against conventional ideas of success and have refused to pursue any kind of career, combining downward mobility with spiritual striving. What torments me is the difficulty of being authentic — of staying true to who I really am, despite the enormous pressures of alienation and conformity.

Beginning in 1984, upon completion of my graduate law degree, and in the years that followed, the life in the law lost any meaning at all. It had become quite apparent to me that I could not be both a creative dreamer and a “solid citizen,” a Faustian seeker and a stalwart member of the middle class. I am but a talented lone wolf. My life has long been restive

and discontented. I am unable to bear a comfortable, established mode of existence for any period of time.

I am in essence a willful, moody person who refuses to fit into his society. Basically I am incurable, for I do not want to be cured; I care nothing for co-ordination and a place in the scheme of things. I love nothing but my freedom, my perpetual indeterminate status, and prefer spending my whole life as the unpredictable and obstinate loner, the ingenious fool and nihilist, to following the path of subordination to social conventions and thus attaining peace. I care nothing for peace, have no regard for the prevailing moral order, hardly mind reproof and isolation. Certainly I am a most inconvenient and indigestible component in a conventional world. But because of this very troublesomeness and indigestibility I nurture a sense that I am, in the midst of such a shallow and prearranged world, a constant source of vital unrest, a reproach, an admonition and warning, a spur to new, bold, forbidden, intrepid ideas, an unruly, stubborn sheep in the herd. I am an obstinate individualist who takes a fierce delight in any situation which places me in a position to challenge the bigwigs and the hierarchy in general, and show them their shortcomings.

I would never be able to satisfy my individualistic strivings in the hierarchical structure of a law firm. The very nature of a law partnership requires that the young associate let his individuality be almost perfectly absorbed in its hierarchic function. And if conflicts arise between the associate and the Powers that Be, firm partners will always regard the associate's ability to subordinate his autonomy as a touchstone for the stature of his personality. The partnership does not approve of the rebel who is driven by his desires and passions to infringements upon convention; indeed, the partnership finds all the more worthy of reverence those individuals who sacrificed themselves for the greater whole. That I could never do. I did not want to follow the path trodden by many, but to resolutely plow my own furrow. I am not made for the collective life.

What did my years working with lawyers teach me? I came to see that lawyers meet with clients and carry on conversations, sit out their hours at desks and on office chairs; and it is all compulsory, mechanical and against the grain, and it could all be done or left undone just as well by machines or robots; and indeed it is this never-ceasing machinery that prevents their being, like me, the critics of their own lives and recognizing the stupidity and shallowness, the hopeless tragedy and waste of the lives they lead.

I live the life of a romantic vagabond, forever exhausted and distraught in my quest for solitude. Before life can ever become meaningful for me, I must find and come to terms with myself. I am forever taking painful stock of myself and devote myself assiduously to solitary pleasures. I live like a hermit in my emotional and financial poverty and for years now, I have rarely left my apartment for more than routine outings. I am unable to bear a comfortable, established mode of existence for any period of time. My life is grim and I live in endless mental agony.

In 1993 I began a writing that was to occupy me for the next ten years. That writing would be my autobiography, *Significant Moments*. The writing reflected my relentless quest for my self, and it assumed a fresh impetus and a new stylistic direction from my restless spirit during those years. I became an uninhibited and exciting innovator. The autobiography was really a tense psychological study and reflected the intoxicating emotional release of a Buddha-like search for the basic unity and meaningfulness of life. I am sure if it were ever to be published it would be greeted with a curious mixture of awe, bewilderment, antagonism, and disgust. My own uninhibited self-exposure would no doubt trouble even the staunchest of my supporters. I must remind you, my reader, that my new literary venture was not an irresponsible deviation but a necessary culmination in my self-quest. It has always been my belief that repressions had to be exposed, even at the price of unpleasant notoriety.

The form of my autobiography is loose, a collection of quotations: a random succession of vignettes and dramatic monologues, held together primarily by their common spirit of decadent romanticism. A Hoffmannesque fusion of fantasy and reality, which is both cynical and morbidly intimate. You, no doubt, would call it the work of a talented beginner whose world of experience is still too limited, and whose imagination is entranced by the facile flow of beautiful language. In the absence of discipline and restraint, I fear that the whole is sacrificed to the part, and what is meant to be art fails to become more than picturesque patter.

The letters I have written about my psychotherapy experience are actually an article of faith and not a document of despair. Yes, I wallow in despair but I live in faith, a faith in the ultimate meaningfulness of life. For me, life has never become the perplexing absurdity it was for Franz Kafka or the Sisyphean monotonous senselessness it was to become for Albert Camus. As I like to say, there is always tomorrow.

Every day for me is an effort. A seemingly senseless effort to survive. So much of my day is marked more by strained effort than by spontaneity, more by futile persistence than by passion, and more by recollection than by new horizons. I relive the past day-by-day.

There has always been a very close relationship between the circumstances of my life and my artistic aspirations. Each represents a different stage in my struggle with myself and with life at large, and each reflects a correspondingly different phase in both the substance and the form of my art. My writings are replete with uncertainty and vague presentiment. I live as a sensitive outsider who cannot cope directly with my particular problem of existence. I resort instead to fantasy and withdraw into the realm of beauty there to indulge in the extremes of late esthetic gratification. My world is one of perfumed melancholy. It is characterized

by exclamatory remarks and rhetorical questions, by sensuous adjectives and adverbs in languid cadence.

In the last year, in my extreme isolation, my writing has become more human and less shadowy; inertia and desperation yield to movement and humor. My prose has achieved a more narrative style, and my language has become leaner, crisper and more forceful.

And yet, despite the emotional gratifications of my splendid isolation in the past year, I was forced to face the overwhelming accumulation of tensions. I was compelled to realize that in my desire to make existence less painful I had been avoiding a close look at the true nature of my inner discord, and had blindsided myself to the morally and spiritually impoverished world around me. In my imagination I left the comfortable fold of the bourgeois world, which had never afforded me the security I had hoped it might, and accepted the more difficult existence of an outsider. Did I have a choice in the matter? In a desperate and determined effort to find myself, I began systematically to diagnose my inner conflicts, to go my long-shunned inward path. Only now did I finally come to grips with the intrinsic problems of human existence - and of my place in the human world.

In my isolation escape became quest, and in quest my inner problems resolved themselves into the basic *malaise humain*, into the tension between the spiritual and the physical. For the past year I oscillated between these poles, acclaiming first one, then the other, then neither. I never ceased hoping for a harmonious accord, though well aware that for me this was impossible. I acclaim spirit, stressing self-knowledge and self-realization with a Nietzschean emphasis upon the superior being. But spirit as a guiding principle of life can only mean greater individuation and more painful isolation. I still lack the firm conviction and the inner fortitude necessary to endure these consequences. The immediate

reaction has been as extreme as the initial impulse. My assertive Nietzschean activism has yielded suddenly to a Schopenhauer-like passivity, a restless quest to a quietistic acceptance, and self-realization to a yearning for self-obliteration.

In the sober tone of acceptance which is evident in this collection of letters I call *Psychotherapy Reflections*, I realize that despite all efforts to the contrary, my existence will probably continue as a restless tension, a constant oscillation between life's opposing poles.

My path to myself has reached its climax in a fascinating confusion of symbol and irony, fantasy and realism.

It is only now that I at last have found the peace of sincere self-affirmation and life affirmation. The individual must take and continue along that path which the predominant aspect of his nature impels him to choose. Each, whether given to the senses or to the spirit, must be prepared to suffer the lot of his kind; to attempt in curiosity or desperation to do otherwise is to foster a perpetual dissension of the divided self.

My center is the individual, opposed to society, its mores, and its institutions. And that individual is myself. I recall, nostalgically, the simpler years of childhood. I re-experience youth with its excruciating years of awakening. I think about modern man, the intellectual and the artist in particular, within the framework of a declining culture.

It is in this, its intimately egocentric nature, that my artistic temperament bears the stamp of its age, an age of cultural decline, of spiritual and moral distress, and of extreme loneliness.

I am predominantly an esthete who lives only in dreams, hopes, and anticipation, and who shrinks before realization. I am a self-preoccupied,

temperamental artist who vainly seeks a kindred soul. I am paralyzed by chronic indecision and indulge in romantic morbidity. I am an outsider consumed by my own hopelessness and loneliness ~ a misfit, to whom the art of life and the art of love are foreign, a timid soul who asks too little of life and expects too much of it. I live in perpetual frustration and disillusionment.

This is what the past year has taught me about myself. The past months that I spent in psychotherapy were not wasted months. I learned many things about myself and in these letters I have tried to memorialize my discoveries and share them with you, my reader.

Therapy Session: May 23, 2018

In this discussion I attempt to show how my preoccupation with psychoanalysis is a rationalization of my deep-seated personality needs. Since my teenage years I have had an interest in the writings of Sigmund Freud and in psychoanalysis. When I was eighteen I purchased a book titled *Character and Culture*, a compendium of several of Freud's non-clinical essays, including "The Theme of the Three Caskets" and "Dostoyevsky and Parricide." I was intrigued by Freud's use of psychoanalysis to explain aspects of creative personalities as well as his use of psychoanalysis to reveal hidden themes in works of literature.

In this letter I also attempt to show how the work of an attachment-oriented therapist – specifically, my therapist's particular interpretation of attachment theory – may be, to some extent, a rationalization of her own personality needs. My therapist consistently abjures classical psychodynamic work, a technique in which the therapist acts as a neutral investigator. Instead, her work relies heavily on soothing and reassurance. At an early session she said, "I have worked with people who were in analysis. Analysts make their patients lie on a couch; they show no compassion for their patients' suffering."

I have identified a set of personality needs or attributes that seem to underlie the gratification I experience by looking at myself through the lens of psychoanalysis – a discipline that allows me to indulge my particular obsession: my concentrated, almost technical interest in my self, as if I were a specimen.

1. **Insecure attachment:** I have an insecure attachment style. I am dismissively avoidant and feel more comfortable in the life of the mind than with social relations. I am socially anhedonic and don't experience the pleasure that securely attached persons derive from social relations. I am creative and independent in thought and action. I am able to "risk

nonconformity.” See Codato, M. and Damian, R. “Creativity and Nonattachment: A Relationship Moderated by Pride.” *Testing, Psychometrics, Methodology in Applied Psychology*, 20(2): 185-195, June 2013 (Rodica Damian was a graduate student of Phillip Shaver's at the University of California-Davis). Creativity, conceived as the ability to produce work or ideas that are original, high in quality and appropriate implies the capacity to “risk nonconformity” and a sort of freedom from the reactions generated by one’s products – to some extent creativity may involve a certain disengagement from personal attachments (or an ability to make adaptive use of a lack of secure attachment). To some extent one can trace many of my social difficulties to a conflict between people of differing attachment needs: as someone who can readily “risk nonconformity” I face the most severe interpersonal problems with people who, because of their attachment style, cannot “risk nonconformity” – these individuals need the safety of conformity in order to preserve their personal attachments. It's a dubious cliché for a therapist to say to me “You need to take risks with people.” Many of the people with whom I have severe problems are those socially-adjusted individuals who *can't risk asserting their individuality* – and in so doing risk a needed social source of identity and security, or to put it in more technical terms, they can't risk losing the social defense against intrapsychic anxieties that group membership affords. We see this as an important aspect of my therapy relationships. I suppose that many patients want to be liked by their therapists, and will feel the need to ingratiate themselves with them or avoid displeasing them. It is well to keep in mind, my favorite therapist (Stanley R. Palombo, M.D.) on different occasions called me a “freak” and a “buffoon.” I didn’t care. My attachment insecurity seems related to the fact that my thinking, behavior, and values are not driven by a need for social approval – a need that one might find in securely-attached persons.

It has been found that rejection may not merely be a result of the unconventionality of creative people but that the actual experience of

rejection may promote creativity, with the effects depending on a person's self-concept. For those who are highly invested in belonging to a group, rejection may constrain them and trigger an attachment response. But for those scoring high in a need for uniqueness, the negative consequences of rejection on creativity may be mitigated and even reversed. For creative people, rejection does not necessarily trigger the attachment response; it may trigger creativity and self-esteem. Kim, S.H. et al. "Outside Advantage: Can Social Rejection Fuel Creative Thought?" These findings add a complication to attachment theory and may pose a problem for attachment therapists.

My attachment style seems related to my moral reasoning. In the view of Lawrence Kohlberg conventional morality is based on the importance of interpersonal relationships. In this stage one tries to conform to what is considered moral by the society that they live in, attempting to be seen by peers as a good person, i.e., they will attempt to harmonize their moral values with the need for social acceptance. My moral reasoning seems related to my diminished need for social acceptance. If a group embarks on a course of action that is contrary to my values, I will not follow the group and subvert my values in the interest of social acceptance. (In the therapy situation, I will not stop writing letters because it risks the disapproval of the therapist.)

Perhaps there is a relationship between attachment style and the willingness of the whistleblower to take the risks. It has been observed that "Whistleblowers blow the whistle because they dread living with the corrupted self more than they dread living in isolation from others."

Alford, C.F. *Whistleblowers: Broken Lives and Organizational Power*.

According to Alford, moral narcissists strive to live up to their introjected values rather than lower the ideal and say to themselves, consciously or not, "Well, I'm just going to go to work every day and go along." Perhaps, individuals such as Gandhi (who engaged in hunger strikes) and Martin Luther King, Jr. were individuals with attachment anxieties who could

risk social opprobrium in the interest of staying true to their introjected values. Such individuals are more concerned with introjected values (see Paragraph 3, below) than with social relatedness. See Martin Luther King, Jr., Speech at Western Michigan University (Dec. 18, 1963) (discussing the importance of “creative maladjustment”).

Finally, it is important to define precisely the psychological state I experience when alone: (1) Do I feel uncomfortable being alone and experience loneliness?; (2) Is my alone state a defensive reaction to fears of rejection associated with insecure attachment; or (3) Do I have the capacity to be alone because of ego maturity. See Winnicott, D.W., “The Capacity to Be Alone.” *Int. J. Psycho-Analysis*, 39:416-420 (1958). According to Winnicott, the capacity to be alone, which is a “mature” internal development on the part of the infant, is a principle component in the development of creativity. The capacity to be alone is manifested in the child as a condition of unintegration, and in the adult as relaxation, although both of these states may be more aptly described as authenticity. In this authentic state, according to Winnicott, the child, adolescent, or adult “is able to exist for a time without being either a reactor to an external impingement, or an active person with a direction of interest or movement.” Is my letter writing a defensive way of coping with loneliness? Is my letter writing a substitute for personal relationships? Or is my letter writing a creative act emerging out the capacity to be alone, and therefore an expression of ego maturity?

2. Reaction formation against anality: I may show rigid reaction formations against anality. “A not infrequent accompaniment [to repressed greed] is pretended contempt for money in real life and ‘moral narcissism,’ that is, yearning to be pure, free of attachment, and above ordinary human needs. Disenchantment with food to the extent of developing anorexia nervosa (compare “Gandhi’s hunger strikes,” see Paragraph 1, above) is often the consequence of such narcissism and repressed [anal] greed.” Salmon Akhtar, *Sources of Suffering: Fear, Greed,*

Guilt, Deception, Betrayal, and Revenge at 40 (2014). My highly-developed moral sense might be a reaction formation against anality. For example, when I applied for Social Security Disability benefits in 1993 I told the SSA in writing, “I believe I am employable.” I was absolutely honest with SSA and did not claim to have a disorder or claim that I was disabled. I reported that it was others who had said I had mental problems and that I was unemployable. I told SSA that I believed I was absolutely able to work. Precious few disability claimants would admit that to SSA.

My absorption in the life of the mind may reflect my need to immerse myself in pursuits detached from ordinary human needs, reflecting a reaction formation against anality. My interest in psychoanalysis – an intellectualized endeavor – may in part be rooted in this defensive need.

3. Introjective Depression: I take pride in my thinking and view my personality problems not simply as mental pain, but also as a puzzle to be solved. I need others as an audience to observe and applaud my grandiose ideas about my personality. My introjective disorder is aggression based. I am much more concerned about self-assertion and aggression than about bonding and relatedness. Blatt, S.J. “Representational Structures in Psychopathology.” Introjective depression is viewed as a structural outcome of a developmental environment in which important attachment figures have been controlling, overly-critical, punitive, judgmental, and intrusive. Blatt, S. J., & Shichman, S. “Two primary configurations of psychopathology.” *Psychoanalysis & Contemporary Thought*, 6(2), 187-254 (1983).

Strengthening the therapeutic alliance is particularly difficult among introjective patients because they tend to have punitive, harsh representations of self and others, which are likely to be projected onto their therapist. Introjective patients will not respond well to therapists who focus on emotional support and gratification of nurturant needs. Introjective patients are unlike clients preoccupied with issues of

dependency, abandonment, and feelings of helplessness who are more invested in connection, and nurturing a collaborative relationship with their therapist—indeed it is through the lens of relationship (as opposed to self-definition) that they see themselves and navigate their world. Put another way, in the relative absence of these preoccupations (i.e., among introjectives), a therapist should perhaps feel less compelled to cultivate and invest in a collaborative relationship. Kemmerer, D.D. “Anaclitic and Introjective Personality Distinctions among Psychotherapy Outpatients: Examining Clinical Change across Baseline and Therapy Phases.”

It is vital to understand that my personality problems do not center simply on the lack of relationships but the *presence* of severe introjective issues. Drew Westen has made an interesting observation about anorexic patients. “If their attitudes toward their needs and feelings in general (and not just toward food) do not become the object of therapeutic attention, they are likely to change with treatment from being starving, unhappy, isolated, and emotionally constricted people to being relatively well fed, unhappy, isolated, and emotionally constricted people.”

Westen, D. and Harnden-Fischer, J. “Personality Profiles in Eating Disorders: Rethinking the Distinction Between Axis I and Axis II.” This is somewhat applicable to me as someone who is both socially isolated and struggling with introjective depression. If my attitudes toward my needs and feelings in general (and not just toward social relations) do not become the object of therapeutic attention, I might change with treatment from being unhappy, isolated, and emotionally constricted to having improved social adjustment but still struggling with depressive states around feelings of failure and guilt centered on self-worth: an individual who remains perfectionistic, duty-bound, and competitive, who feels like he has to compensate for failing to live up to unreasonable introjected standards.

Perhaps an analogy might be useful. Reduced blood flow to the heart will cause a heart attack, resulting in the death of heart tissue and the development of scar tissue. Even if blood flow is restored, the scar tissue will remain. Think of blood flow as analogous to social relations, and reduced blood flow as analogous to attachment problems. Then, think of the scar tissue as analogous to introjective problems that will remain even if social relations are improved.

From an adaptive standpoint it is well to keep in mind that creative personalities score highest on aggression, autonomy (independence), psychological complexity and richness, and ego strength; their goal is found to be "some inner artistic standard of excellence," that is, introjected values. MacKinnon, D. W., "Personality and the Realization of Creative Potential." *American Psychologist* 20: 273-81, 1965.

4. Extravagant Need for Transitional Objects: It may be useful to view me as a middle-aged man who is desperately tied to a symbolic teddy bear or comfort blanket. It's as if my intellectual pursuits were symbolic transitional objects. In therapy it would be useful to look at why I have a desperate need for transitional objects and what that need says about my relationship with my mother.

Winnicott introduced the concepts of "transitional objects" and "transitional experience" in reference to a particular developmental sequence. With "transition" Winnicott means an intermediate developmental phase between the psychic and external reality. In this "transitional space" we can find the "transitional object". The transitional object is a bridge, or space, between the child's inner world and the outer world of objective reality. The transitional object is an outgrowth of the child's emerging autonomy from mother: as symbiosis is superseded by the infant's sense of omnipotence ("mother comes to me when I wish it"); superseded by the child's painful sense that mother is a separate person who is not under his control, which tells the child that he has lost

something; superseded by the transitional phase in which the child learns that through fantasy he can imagine the object of his wishes and find comfort.

A transitional object (a blanket or teddy bear or such) can be used in this process. In this regard is it not important to see the connection of transitional phenomena to my insistent feeling that I need a form of psychotherapy – namely, psychodynamic (or analytic) therapy – in which my private world of unconscious fantasies, wishes, conflicts and prohibitions can be made public through the use of language? That is, for me the therapeutic narrative (which I summarize in my letters) is perhaps a transitional object. See Favero, M. and Ross, D.R. “Words and Transitional Phenomena in Psychotherapy.”

Is it possible that ideas and intellectualized constructs as well as my letters are a transitional object that allow me to make my inner world intelligible to the world of objective reality? When I was a small kid I had a set of wooden blocks. This was one of my favorite toys. I would spend a considerable amount of time working and reworking the arrangement of the blocks in novel structures that suited my fancy. My letters to my therapist are arrangements and rearrangements of ideas. Many of the ideas I borrow from technical psychoanalytic sources. My letters and their composite ideas are like a castles I have built of wooden blocks. Each wooden block – arranged with other blocks to form a composite structure – is a mere instrument used in the service of the expression of an inner truth, a psychological truth, embodied in the castle I have created. It is well to keep in mind that with the transitional object the individual manages the relations between the outer objective world and the inner world of subjective experience. In my wooden castles I have used concepts of the outer world of knowledge (wooden blocks) to express an inner world of subjective experience (the castle).

People may say, “Does he even know what he’s talking about?” Does he even understand Kohut and Klein? My response is – does that matter?

One should look for meaning in the “castle” I have built: why that arrangement of blocks satisfies me — why that overall structure satisfies me. One should see each letter as an aesthetic construction that lies beyond truth or persuasive power. One should look for the truth of the letter in the subjective meaning of the castle as a whole — the way one would look at a painting, which is fundamentally a composite of colors and shapes.

Lerner and Ehrlich write: “The specific form of transitional phenomena will differ at each stage due to maturational and developmental shifts in cognitive functioning, libidinal focus, affect organization, and the demands of the environment. The level of cognitive maturity as well as other dimensions of personality become particularly important in determining and delimiting the manifest forms of transitional phenomena. As other functions including self- and object- representations become increasingly differentiated, transitional objects are thought to become increasingly less tangible and more abstract. For example, *in contrast to the transitional objects of early childhood, the transitional phenomena of adolescence such as career aspirations, music, and literature are more abstract, ideational, depersonified, and less animistic. They are also increasingly coordinated with reality. Rather than the concrete fantasy representation, it is the ideas, the cause or the symbolic value that becomes important.* Regardless of manifest content of the transitional object, transitional phenomena are thought to promote the internalization of core self-regulatory functions that include narcissistic regulation in terms of sustaining self-esteem, drive regulation, superego integration, ego functioning, and interpersonal relationships. Through the use of increasingly abstract transitional phenomena, the individual is better able to synthesize discrepant events in his or her life experience. Representational capacities evolve in concert with and become more complex because more alternative solutions and choices can be conserved simultaneously. With increased development, the function of transitional phenomena may also change from one of self-soothing to

one of enrichment the quality of experience.” Lerner, H.D. and Ehrlich, J. *Psychodynamic Models*.

In therapy, the question is “How does my extravagant need for symbolic transitional objects relate to my personality and my relationship with my mother?”

THOUGHTS ABOUT HOW AN ATTACHMENT-ORIENTED THERAPIST MIGHT USE ATTACHMENT THEORY TO RATIONALIZE HER REGRESSED, UNCONSCIOUS PSYCHOLOGICAL NEEDS

My therapist says she isn’t interested in categories and labels. She has said she does not believe in the diagnostic category, borderline disorder. She seemed to show no interest in my psychological test results. My subjective feeling is that she engages in a persistent assault on my individual identity. She has attacked Freud and psychoanalysis as lacking in compassion – as if the role of the therapist were to nurture the patient.

She employs attachment theory: a theory that focuses on the infant’s relation with mother – keep in mind, infants have no firmly developed identity, that is, no conflicts, defenses, or internal prohibitions. Infants are simply a bundle of biological needs and rudimentary personalities. Infants are undifferentiated. They do not have the highly-developed character organization or particularized personality needs of adults.

Random thoughts:

The young Freud was fascinated with Darwin’s work. (*[When I was a teenager,] the theories of Darwin, which were then of topical interest, strongly attracted me, for they held out hopes of an extraordinary advance in our understanding of the world[.]*) Think about the title of Darwin’s celebrated book, “The Origin of Species.” Darwin could have called his book, “The Origin of Biological Categories.” Darwin was interested in labels and categories. *Darwin created organization.*

Freud introduced the term psychoanalysis in 1896, borrowing "analysis" from chemistry, Lieberman, E.J. *Acts of Will: The Life and Work of Otto Rank*. Apparently, he saw a connection between the analysis of personality and chemical analysis. I think about how each of the chemical elements is unique. Each chemical element has a unique atomic number.

Mendeleev had the insight to see that if one arranged all the elements in a particular way, they would fall into "periods," or categories (The Periodic Table of the Elements). Mendeleev created categories. Mendeleev created organization. *The categorization of personalities reminds me of the Periodic Table.* Patients are unique, but they fall into diagnostic categories.

Is it simple coincidence that Freud had an intellectual attraction to Darwin (whose work focused on the distinct identity of individual species) and apparently thought in terms of chemistry (a field of study that concerns itself with chemical elements, each with a unique atomic number, a unique identity) — and that my personality resembles Freud's in important ways, such as, in my psychological mindedness, my interest in the unconscious meaning of dreams and in the inner world of wishes and fantasies, and in my passion for research, analysis, and categorization? I am curious about my therapist's preoccupation with the *outer world* of interpersonal relatedness, her tendency to view people as an undifferentiated mass, and her corresponding apparent lack of concern for individual uniqueness — and my own concern for the *inner world* of individuals whom I see as *distinct*. I am curious about how my therapist's concern for *massification* contrasts with my own concern for *individuation*.

I think of the following:

The psychoanalyst Janine Chasseguet-Smirgel noted how the Marquis de Sade represented *the anal sadistic urge to destroy differences and undo organization*. His helter-skelter coupling of sister and brother, parent and child, etc. — is done not merely to satisfy forbidden incestual wishes.

Rather, “incest is linked to the abolition of ‘children’ as a category and ‘parents’ as a category.” *Sade wished to destroy the actual world of differences, of categories, of stations, and create an “anal universe where all differences are abolished.”* Volney Patrick Gay, Freud on Sublimation: Reconsiderations (emphasis added).

Chasseguet-Smirgel saw anal sadism as driving the need to see individuals (or any objects that have a specific identity) as **indistinguishable from each other.** In her essay “Perversion and Universal Law” Chasseguet-Smirgel refers to “an anal universe where ***all differences are abolished*** . . . All that is taboo, forbidden, or sacred is devoured by the digestive tract, an enormous grinding machine disintegrating the molecules of the mass thus obtained in order to reduce it to excrement.” In the anal universe Good and Evil are synonymous.

The psychoanalyst Bela Grunberger saw an expression of anal sadism in the treatment by the Nazis of concentration camp inmates. Inmates were identified by numbers rather than by names. “The anti-Semite’s specific [anal] regression is most clearly seen in his representation of the Jew. This follows the line of destroying his individuality. The Jew is denuded of all personal characteristics[:] . . . in the concentration camps they were *designated by numbers.*”

The psychoanalyst Leonard Shengold seems in accord: “‘Anal defensiveness’ involves a panoply of defenses evolved during the anal phase of psychic development that culminates with the individual’s power to reduce anything meaningful to ‘shit’ –to the nominal, the degraded, the undifferentiated.” Shengold, L. *Soul Murder: The Effects of Childhood Abuse and Deprivation.*

The psychoanalyst Jessica Benjamin seems to imply a possible deep connection between the *anal sadistic* urge to denude another of identity,

on the one hand, and a perverse interpretation of attachment theory, on the other, as it relates to issues of mother-infant bonding.

I am not attacking attachment theory, which stands on its own as a valid perspective. I am not attacking attachment-oriented therapists.

But I wonder about the attraction of attachment theory to certain therapists of a particular personality type:

Is attachment theory particularly attractive to therapists with an unconscious anal sadistic trend who are pathologically tied to mother? I have the intuitive feeling that my therapist persistently attempts to nurture me. Is my therapist determined to undo my identity in an attempt to define her own identity? Isn't that psychologically exploitive? Isn't that what happens in cults? The cult leader defines himself by stripping cult followers of their distinct identities in the process of subjugating cult members to an indissoluble bond. In the cult the implicit connection between *identity* and *attachment* seems manifest. Do cult members represent the symbolic mother for the leader from whom the cult leader is psychologically unable to separate?

"Chasseguet-Smirgel's interpretation of sadism as the de-differentiation of the object by alimentary reduction does not fully elaborate the function of anal sadism for the self in relation to other. Her analysis emphasizes only one side of the sadistic act. The act aims not only at de-differentiating the self: the self imagines that in reducing the other it is establishing its own identity. Because it imagines that in digesting the other it is nourishing its own identity, its effort to gain control over the other actually represents an effort to separate, to achieve its own autonomy. The paradigmatic other [such as the followers of a cult leader] who is being reduced is the mother, from whom the sadist [or cult leader] feels unable to separate." Benjamin, J., *Like Subjects, Love Objects: Essays on Recognition and Sexual Difference*.

May we say that for some attachment therapists the patient is the symbolic mother, and that – in a parallel process – the therapist rationalizes the use of attachment theory in clinical practice to work through her personal issues of control and separation, denuding the patient of individual identity in an effort to achieve her own autonomy? Would such a therapist denigrate the patient's struggle for personal identity and view the patient's use of categories and labels as antithetical to her regressed need to undo organization and nourish her own identity and gain control of the patient? One wonders?

I am concerned about what regressed psychological needs of a therapist are gratified by reducing an individual to the simple needs for unconditional acceptance and emotional responsiveness by another. Mother-infant attachment is fundamental and necessary to adult functioning but it is not sufficient to understanding the needs of an adult. I will venture to say that in any science, rudimentary aspects of a phenomenon are fundamental and necessary to understanding the phenomenon but will likely not be sufficient. For example, the biochemist knows that a fundamental and necessary part of understanding biochemical processes is a firm grounding in basic inorganic chemistry – but it is not sufficient. In attempting to understand any complex system – and the personality is a complex system – reductionism will not necessarily provide a sufficient explanation for a problem.

The fundamental conundrum I grapple with is why a therapist would find it psychologically gratifying to apply a reductionist approach to understanding problems of personality and social adjustment that involves denuding a client of what makes him a singular individual with particularized needs and character organization. Might some attachment-oriented therapists have an unconscious, irrational agenda in doing so?

There is some circumstantial evidence that attachment theory might have a special appeal to therapists who have an over-idealized view of

motherhood. John Bowlby, originator of attachment theory, himself might have had attachment anxieties and his theory might have grown out of an idealized worldview: “Bowlby’s ideas, perhaps, are the result of his disappointment with a mother who possibly did not give him what he most craved and his resentment towards her due to her favouritism of his brother, Tony. Maybe his belief that women should be the carers was the result of an idealised view of reality.” Fears, R.M. *Attachment Theory: Working Towards Learned Security*.

The following is an email exchange I had with Phillip Shaver, Ph.D. at the University of California, Davis. Dr. Shaver is one of the world's foremost authorities on attachment theory. He has authored more than 300 books and articles on the subject as well as the definitive 1,000-page text on attachment theory. Rodica Damian, whose work was cited above, was a graduate student of Dr. Shaver's at UC Davis. Rodica Damian et al. observed: “Creativity, conceived as the ability to produce work or ideas that are original, high in quality and appropriate implies the capacity to “risk nonconformity” and a sort of freedom from the reactions generated by one’s products – to some extent creativity may involve a certain disengagement from personal attachments (or an ability to make adaptive use of nonattachment).”

Dr. Shaver:

May I share with you this layman's thoughts about Bowlby and attachment theory?

A major flaw in Bowlby's attachment theory, as I see it, is that it fails to account for the uniquely human aspect of the human animal. Bowlby tried to link human development to biology and looked to ethology (the study of animal behavior) as a model for human psychology. The problem is that chimpanzees or wolves can't write Hamlet, listen to Beethoven, enjoy baseball, or create civilization — all issues that occupy psychoanalysis, whose preoccupation with the internal world of fantasy is dismissed by Bowlby. See Mattson, M.P. “Superior pattern processing is

the essence of the evolved human brain.” *Front. Neurosci.* 2014; 8: 265 (2014) (while human babies may resemble chimpanzee babies in behavior, humans’ capacities for reasoning, communication and abstract thought are far superior to other species and gross anatomy of the brains of each species reveals considerable expansion of three regions in humans: the prefrontal cortex, the visual cortex, and the parietal–temporal–occipital juncture).

If you look only at the intersection of the human and the animal, you end up with the central red area of a Venn diagram, but what about the rest of the circle? What about the uniquely human aspects of the human animal – issues addressed by psychoanalysis? People say attachment theory has a scientific basis that psychoanalysis lacks. What scientific models can explain Hamlet, Beethoven, baseball – or human civilization? It’s a ridiculous argument. Yes, the human animal, like the monkey, can be reducible to science. But the human mind is neither reducible in its entirety to a science nor to a mystery, but encompasses elements of both.

Do chimps and wolves, two social species, have a desire for individuality and autonomy comparable to that found in humans? There are limitations to the use of ethology to understand the importance and adaptive value of human strivings for individuality and autonomy – not to mention the adaptive value to humans of having a rich inner world of fantasy. See, e.g., *Advances in the Study of Aggression*, Volume 2, edited by Blanchard, R.J. and Blanchard, D.C. (London: Academic Press, 1986) (There is empirical and theoretical interest in the direction of understanding the functional or adaptive value of fantasy activities. Why do individuals dream, daydream, engage in imaginative play, write dramas, or go to the theater? What adaptive value do these activities –all transformations of intrapsychic fantasy, or psychic reality – have?). See also, Palombo, S.R. *Dreaming and Memory: A New Information-Processing Model* (New York: Book World Promotions, 1978) (dreams serve an information-processing function by matching present and past

experience in determining what information will be filtered through for storage in permanent memory).

Also, can mental functioning be reduced to simply issues of attachment and the child's registration of objective reality, without consideration of the (adaptive and maladaptive) role of psychic reality (dreams, fantasies, wishes – that is, psychic derivatives of biology) in refashioning objective reality? (Bowlby once famously said of psychoanalysis: "I think that's all rubbish, quite frankly.") Creativity in science is rooted in unconscious fantasy. It has been found that the creative scientist shows a preference for irregularities and disorder, he temporarily takes leave of his senses, permitting expression of unconfigured forces of his irrational unconscious (an irrational unconscious whose dynamic power is denied by Bowlby). Boxenbaum, H. "Scientific creativity: a review." Drug Metab. Rev. 23(5-6):473-92 (1991).

Attachment theory posits that human beings have an innate biological drive to "seek proximity to a caregiver in times of alarm or danger". We're "hardwired" – programmed in our brains – to "attach" to someone for physical safety and security. Attachment theorists like to point out that research has proven this hypothesis beyond irrefutability and prioritizes it even over the drive for food. This hardwired attachment behavior becomes a powerful ally in the healing process in therapy; clients can use the therapist as an "attachment figure" to experience safety, protection, a "secure base" in times of alarm or perceived danger and, over time, internalize that secure base within themselves.

How do attachment theorists reconcile their view of mental health – a view that emphasizes healthy dependence on the mother as primary attachment figure and on social relations and groups in adulthood – with the functioning of creative persons who place a premium on autonomy, emotional detachment, independence of thought and behavior, and a reliance on the self as the ultimate source of identity and security?

Research shows that even in childhood the potentially creative child exhibits unusual autonomy from his parents.

In studies many creative subjects indicated that as children they had enjoyed a marked degree of autonomy from their parents. They were entrusted with independent judgment and allowed to develop curiosity at their own pace without overt supervision or interference. Donald MacKinnon noted of these parents, “They did not hesitate to grant him rather unusual freedom in exploring his universe and in making decisions for himself — and this early as well as late. The expectation of the parent that the child would act independently but reasonably and responsibly appears to have contributed immensely to the latter’s sense of personal autonomy which was to develop to such a marked degree.”

But this autonomy has been shown to have a darker side — it coexists with a certain emotional detachment from one or both parents. According to attachment theorists emotional detachment is a mark of insecure attachment and fear of rejection.

In one study creative subjects often reported a sense of remoteness, a distance from their elders — i.e., markers of insecure attachment dating back to infancy — which ultimately helped them avoid the overdependence — or momentous rejection — that often characterizes parent-child relationships, both of which were believed to interfere with the unencumbered unfolding of the self through the creative process.

In a study of eminent scientists Anne Roe found that many subjects had quite specific and fairly strong feelings of personal isolation when they were children (suggestive of insecure attachment). They felt different, or apart, in some way. Such statements as the following from physicists, in particular, were strong: “In college I slipped back to lonely isolation.” “I have always felt like a minority member.” “I was always lonesome, the other children didn’t like me, I didn’t have friends, I was always out of

the group. Neither the girls nor the boys liked me, I didn't know why, but it was always that way."

In a study of architects MacKinnon found that the least creative showed the following characteristics seemingly associated with secure attachment: abasement, affiliation, and deference (socialization); their goal was to meet the standard of the group (i.e., the attachment figure). MacKinnon, D.W. "Personality and the Realization of Creative Potential." *American Psychologist* 20: 273-81, 1965. The most creative architects scored highest on aggression, autonomy (independence), psychological complexity and richness, and ego strength (will); their goal was found to be "some inner artistic standard of excellence." Cattell found that high ego strength (found in creative persons) was associated with being self-reliant, solitary, resourceful, individualistic, and self-sufficient: characteristics seemingly associated with insecure attachment. In creative persons are the characteristics of aggression, autonomy, psychological complexity and richness and ego strength associated with insecure attachment?

How does attachment theory reconcile the fact that although attachment is biologically-driven, the emotional detachment associated with insecure attachment – with its consequent promotion of unusual autonomy and creativity – has survival value for the group?

It is important to keep in mind, as Stephen Jay Gould (1981) has pointed out, that natural selection may produce a feature for one adaptive reason (e.g., the drive for attachment which promotes infant survival and group cooperation in adulthood). However this may have a number of potentially "non-adaptive sequelae" – such as the compromising of individual identity in the drive for group cohesion, the loss of rationality and the development of "group think", and the scapegoating of creative outsiders who pose a threat to group cohesion. In short, there is no guarantee that all features of biology are adaptive. Another example: African populations who moved to Europe eons ago lost their skin pigmentation that allowed these European populations to more easily

absorb vitamin D at higher latitudes. With that biological advantage there arose a disadvantage: the greater risk for skin cancers in these northern populations. We should emphasize that individuals who do not conform to biological imperative (e.g., persons with insecure attachment) may have qualities that prove to be biologically adaptive for the group (such as, heightened autonomy, which promotes novel problem-solving skills that have survival value for the group).

It's virtually meaningless and deceptive for attachment therapists to propose that secure attachment is an ideal to which all must aspire. The issue is what one is comfortable with. Is the individual happy to be insecurely attached with a lessened need for social bonding and relatedness but a superior ability to tolerate being alone with the concomitant ability to nurture his creativity?

Evolution is more complex than Bowlby seems to assume. Positive (good) things can come from negative (bad) things and negative (bad) things can come from positive (good) things. Secure attachment is not all good and insecure or anxious attachment is not all bad. As the CBT practitioner likes to say: black and white thinking is a cognitive distortion.

Gary Freedman
Washington, DC

Reply from Dr. Shaver. Significantly, Dr. Shaver emphasizes that “no one in the attachment field ever claimed that attachment is everything” and that *insecure attachment is as valid an attachment style as secure attachment.* Whether any attachment style is “good” or “bad” depends on the individual’s circumstances – whether the attachment style is adaptive to his environment and ego-syntonic. Dr. Shaver would say to an avoidant individual, “If you are an insecurely attached individual who likes to spend time alone listening to Beethoven on his iPod while watching people walk down the street on Connecticut Avenue, there’s nothing wrong with that.”

From: Phillip R. Shaver
To: Gary Freedman
Sent: Sun, Nov 19, 2017 2:49 pm
Subject: Re: SPN Profile Message: problems with Bowlby

Hi. I don't have time to respond in detail, but you are ignoring the fundamental concept in the theory: "a secure base FOR EXPLORATION." That was the idea that motivated Ainsworth's development of the strange situation assessment procedure. So basically you are running wild in a direction that ignores a centerpiece of the theory.

Secondly, Tsachi Ein-Dor and some of the rest of us have published several papers showing that people who score fairly high in attachment anxiety or avoidance make important contributions to the groups they belong to. The anxious individuals are sensitive to threats and are quick to mention their worries to others (they are also better at detecting bluffing during poker games). The avoidant individuals are quick to see how to save themselves in a threatening situation, and while avoiding harm to themselves often inadvertently save other people by countering a threat or seeing a way to escape, inadvertently showing others how to escape. In one of our studies we found that avoidant young pre-professional singles tennis players have better records than less avoidant players, perhaps because they can hold up better while traveling and competing alone. Aside from all these details, I would say that no one in the attachment field ever claimed that attachment is everything.

Bowlby was primarily focused on infancy, and human infants are more like monkey infants than adult novelists are like adult monkeys. Bowlby was also a clinician, so he was looking at possible early experiences that presaged later mental health problems, later delinquency, etc. In the adult realm, he focused mostly on loss and grief, which is a core process that may be more similar in monkeys and humans than is, say, painting or comedy writing. So, to make the 1000-page 3rd edition of the Handbook

of Attachment, plus thousands of research articles not covered there, short, I think you're running wild in a direction not much addressed by attachment researchers but not at all incompatible with the theory.

But maybe I would have a more refined opinion if I had time to look into it. I am a 73-year-old retiree and member of my County Grand Jury, so I don't have much time at the moment to defend Bowlby, who is long dead but clearly made major contributions to science and society. He doesn't need much defending, especially with respect to what he didn't write about.

Sent from my iPhone

Reply from Gary Freedman:

On Nov 19, 2017, at 11:27 AM, Gary Freedman <garfreed@netscape.net> wrote:

Thank you so much for your thoughtful and useful reply. I have been led astray about attachment theory by my very socially-oriented relational therapist who seems unable to see anything positive about my avoidant, independent-minded traits. Thanks again for the information. I'll have to read more!!

Gary Freedman
Washington, DC

Reply from Dr. Shaver:

~~Original Message~~

From: Phillip R. Shaver <prshaver@ucdavis.edu>
To: Gary Freedman <garfreed@netscape.net>
Sent: Sun, Nov 19, 2017 2:49 pm
Subject: Re: SPN Profile Message: problems with Bowlby

Sounds good. One's view of these matters depends on one's values, which are in turn somewhat related to one's attachment history. Therapists are generally interested in how a person's history, including family history, has led to a person's current problems. If an anxious or avoidant person has made a series of happy life choices that fit with his or her attachment orientation, he or she will not show up for therapy, so therapists need not worry about those successful adaptations. (I've always thought that an avoidant person might be a good spy, for example, because he could go somewhere alone, maintain a fake identity, and take advantage of people without feeling too bad about it. But he might also become a double agent without guilt, as has often happened with actual secret agents.) Therapists are generally trained to notice when symptoms are or are not "ego-syntonic."

For example, Donald Trump obviously qualifies as having a narcissistic personality disorder, but there's no indication that this bothers him, makes him unhappy, or keeps him from succeeding in life. As with avoidance, however, narcissism may not be good for one's close relationship partners, as we see with The Donald's three wives and many cheated and abandoned business partners. A less extreme example is Steve Jobs. I'm typing on one of his wonderful products, but he was often hell to live and work with.

Sent from my iPhone

FINAL THOUGHTS – GOALS IN THERAPY

Any therapist reading this letter might well ask: "If you are happy sitting alone on a park bench listening to Beethoven on your iPod, what do you want to accomplish in therapy?"

I would like to work on the following issues:

I would like to become more fully who I am. I would like to grow as a whole person. I would like to work on my psychological distress – depression, anxiety, relationship difficulties, and the like.

I would like to develop insight about the ways in which I distance myself from painful thoughts and feelings (dissociation), repeat old relationship patterns, and prevent myself from fulfilling my potential.

Specific symptoms that I need to work on are my dissociated lack of awareness of social needs; anhedonia or an inability to experience pleasure (and a corresponding ascetic trend not unlike anorexia nervosa in which I disdain pleasure); my extravagant narcissistic need for twinship, idealization and mirroring that has led to disastrous consequences for me – as well as the flip side of the coin, namely, my intense feelings of alienation when I am with people who cannot satisfy my narcissistic hunger for self-sameness; and why it is that I serve – and seem to need to serve – as a repository for the unconsciously warded-off mental contents of members of groups (i.e., my tendency to be scapegoated).

ADDITIONAL THOUGHTS ABOUT DR. SHAVER'S MESSAGE:

Dr. Shaver said something that was remarkably ironic:

“I don’t have much time at the moment to defend Bowlby, who is long dead but clearly made major contributions to science and society. He doesn’t need much defending, *especially with respect to what he didn’t write about.*”

John Bowlby ridiculed psychoanalysis because of its emphasis on psychic reality, or intrapsychic fantasy. Concerning psychoanalysis he once famously said, “I think that’s all rubbish, quite frankly.” Bowlby is on record as saying that Melanie Klein, Bowlby’s supervising analyst, denied the importance of real relationships. Morris Eagle writes: “Bowlby[] claim[s] that from the start [the] infant is capable of reality

testing rather than having to rely on a complex set of projective and introjective processes in order to ‘construct’ an external world. Th[is idea] may not have been [] explicitly stated by Bowlby. However, I believe that [it is] at least implicit [in] aspects of Bowlby’s general attitude and skepticism toward Kleinian theory. [Bowlby’s criticism is not] justifiable. The passage cited from [Bowlby’s training analyst, Joan] Rivière in Chapter 1, and Bowlby’s response to it (“**role of environment = 0**”) notwithstanding, as we have seen in a previous chapter, Kleinian theory does not discount the role of actual events in the development of the child. Although the emphasis on endogenous instincts remains, an assumption of Kleinian theory is that one needs good object experiences in order to modulate hate and destructiveness emanating from the death instinct and to strengthen object love and the life instinct.” Eagle, M. *Attachment and Psychoanalysis: Theory, Research, and Clinical Implications*

“Role of environment = 0”? Melanie Klein never said that.

Again, Greenberg and Mitchell write: “**Real other people are extremely important** in Klein’s later formulations. The child regrets the damage he feels he has inflicted upon his parents. He attempts to repair that damage, to make good, over and over again. The quality of his relations with his parents and the quality of his subsequent relations with others determine the sense he has of himself, in the extremes, either as a secret and undiscovered murderer or as a repentant and absolved sinner.”

Greenberg, J.R. and Mitchell, S.A. *Object Relations in Psychoanalytic Theory* at 127 (Cambridge: Harvard University Press, 1983).

To paraphrase Dr. Shaver: I don’t have much time at the moment to defend psychoanalysis and Melanie Klein, who is long dead but clearly made major contributions to science and society. She doesn’t need much defending, especially with respect to what she didn’t write about.

Therapy Session: May 29, 2018

At the outset of this session I stated my goals in therapy, rendered in the following paraphrase:

I need to work on dissociation; masochism (an ascetic trend not unlike anorexia nervosa in which I disdain pleasure); the inability to derive pleasure from social relations; my extravagant narcissistic need for twinship, idealization and mirroring that has led to disastrous consequences for me – as well as the flip side of the coin, namely, my intense feelings of alienation when I am around people who cannot satisfy my narcissistic hunger for self-sameness; my lack of interest in social relations (metaphorically, I would like to experience hunger); and why it is that I serve – and seem to need to serve – as a repository in groups.

We will return to this issue later.

Sometime later, in another context, I told my therapist that the previous November my former therapist had given me a mini-lecture on attachment theory; that her comments aroused my curiosity about attachment theory; and that I began to read about it. I explained that I had formed questions and concerns about attachment theory — concerns about basic tenets of the theory. I further said that I found the name of a leading expert (Phillip Shaver) on attachment theory, and sent him an email in which I discussed my critical comments about the theory. I said that I was surprised that a few hours later Dr. Shaver responded to me with substantial comments about my email, and elaborated aspects of attachment theory. My therapist and I discussed the fact that Dr. Shaver had offered comments about attachment theory that seemed to contradict my therapist's seemingly deeply held ideas about attachment theory, namely, that secure attachment is the ideal type of attachment to which everybody should aspire. My therapist offered the comment that perhaps Dr. Shaver's views were not all that different from her own.

My therapist and I got into an intellectualized discussion about the content of Dr. Shaver's email. The therapist showed no interest in the relational aspects of my communication with Dr. Shaver, such as, "How did you feel about getting a response from Dr. Shaver?" "Have you ever done anything like this before?" "Do you have a fantasy about seeing a therapist who is a leading authority in the field?" "Have you ever shared your ideas with other experts?"

At a later point in the session, the therapist said, "You think you're smarter than everybody else."

At another point in the session, I told the therapist an anecdote to illustrate my problems with peers. "When I was in my second year of college, I took an introductory course in public speaking. We had to give three speeches that semester. After one of my speeches the instructor said that my speech was the finest speech any student had given in about the last three semesters. Then in my next class — I remember it was biological science, a large lecture hall class — there was a student who had been in my speech class. He was sitting across the lecture hall and yelled out to me, 'You are so weird, man! You are so totally weird!'"

Why did my peer have a negative reaction to me? Is it that I gave the impression that I thought I was smarter than everybody else? Or was it that an instructor had singled me out for unusual praise in a class in which some students struggled with stage fright? Was there an element of jealousy in the student's negative response? Compare the situation at this therapy session: I told the therapist that one of the world's leading authorities in attachment theory — my therapist's own field of interest — had "singled me out" by responding to my layman's critique of attachment theory and that Dr. Shaver had offered comments about attachment theory that seemed to contradict the therapist's seemingly deeply held ideas about attachment theory, namely, that secure attachment is the ideal type of attachment to which everybody should aspire.

But there is another issue concerning that incident from college. I told my therapist about the topic of my speech that had been singled out for praise. In my speech to my college class I talked about my belief that people should not seek pleasure in life, that a person should just live and if one finds something pleasurable he should enjoy the experience, but that he should not make pleasure-seeking his goal in life. These are peculiar ideas for an 18-year-old. Most teenagers are pleasure-seeking creatures. They live for pleasure. In fact, my instructor commented: "You must be a lot of fun at parties!" Did my fellow student, my peer, react negatively to my thinking, my rationality and my individuality? Was the fellow student's negative reaction to me fundamentally a negative reaction to my autonomy and the fact that I expressed values inconsistent with those held by most teenagers?

A digression:

I have had severe interpersonal problems in the workplace. I worked as a paralegal for three-and-a-half years at a large law firm where I encountered notable difficulties. I was terminated days after I lodged a harassment complaint against my supervisor, a known racist, who had earlier described me in a written performance evaluation as being "as close to the perfect employee as it is possible to get." The employer later alleged in an apparently perjured sworn statement it filed with the city government that the firm learned that I had severe mental problems: reportedly, according to the firm, I had delusions of persecution, frightened my coworkers, was potentially violent in the opinion of a psychiatric consultant, and — according to my supervisor — potentially homicidal. (The employer never contacted the police, by the way!)

I can't say with certainty why I had problems in the workplace, but group theory offers a tantalizing explanation. Otto Kernberg, M.D. points out that individuals in groups tend to develop a group identity and subvert their individuality in the interest of homogenization and group cohesion. Individualists will be targeted for aggression in cohesive groups in which

group members have regressed to the state of an undifferentiated mass. Kernberg writes: “[Group theorists] describe the complete loss of identity felt by the individual member of a large (unstructured) group.” “[Group theorists] also describe the individual’s fears of aggression from other members, loss of control, and violent behavior – fears that can emerge at any time in the large group.” “Gradually, it becomes evident that those who try to maintain a semblance of individuality in this atmosphere are the ones who are most frequently attacked.” “For the most part aggression in the large group takes the form of envy – envy of thinking, of individuality, and of rationality.” Kernberg, O.F., *Ideology, Conflict, and Leadership in Groups and Organizations*.

Incidentally, the late Gertrude R. Ticho, M.D., my former employer’s psychiatric consultant, whose professional opinion about me was the basis of the Social Security Administration’s later determination that I was disabled and unemployable, happened to be a personal friend and professional colleague of Dr. Kernberg’s. Dr. Ticho did not examine me personally; the firm claimed that it spoke about me with Dr. Ticho, a psychiatrist I never met, over the telephone.

I have experienced considerable difficulties in my relationships with my therapists and in the workplace. Query: Are my problems with therapists and with peers the result of my grandiose belief that I am “smarter than everybody else” or are my interpersonal difficulties linked to my thinking, my individuality, and my rationality in the face of group-oriented people (including therapists) who want me to regress to the state of an undifferentiated individual who has no rationality or distinctive thinking?

Group theory raises an additional question about my therapist’s reaction to me. Theorists maintain that helplessness and the fear of annihilation precede the emergence of envy in some groups. Hopper, E. “The Theory of the Basic Assumption of Incohesion:Aggregation/Massification or (BA)I:A/M.” Return for a moment to the opening of my therapy session. I told my therapist my goals in therapy. Are the issues I described ones

that my therapist would be able to treat? How do you use attachment theory to help a patient experience social “hunger” if he doesn’t feel hunger? Indeed, in the remainder of the session my therapist never addressed the issues of my lack of social “hunger” (social anhedonia) and feelings of alienation, but continued to pursue the issue of approach avoidance. Is it possible that my therapist had unconscious feelings of helplessness along the lines, “How in the world do I treat these issues? There is no way for me to help this patient if these issues are in fact his problem.” Did the therapist’s unconscious feelings of helplessness trigger her possible feelings of envy of me that took the form: “You think you are smarter than everybody else?”

Is it possible that the therapist was thinking at some level: “You are able to help me help you, but you are not cooperating with me. You resist me and thwart me.” Group theorist Earl Hopper offers insight into the possible psychodynamics of such thoughts: “Malign envy is directed towards *objects who are perceived as able but unwilling to help*, and who are perceived as responsible for failed dependency, that is, failed containment, holding and nurturing. In other words, according to this perspective, malign envy is not innate, but develops as a defense against feelings of profound helplessness, which are a consequence of traumatic experience.” Hopper, E., *Traumatic Experience in the Unconscious Life of Groups*.

By the way, Stanley R. Palombo, M.D., my former psychiatrist, once said that I seemed to have struggled in childhood with family members’ jealousy. No other therapist I’ve seen has ever mentioned that. Dr. Palombo was an individualized thinker who never showed any trace of jealousy or envy of me. Unlike my other therapists, Dr. Palombo was also a psychoanalyst who had undergone a training analysis and was presumably aware of, and able to control, his baser instincts.

Group theorist, Wilfred Bion's core insight about groups was that human beings are group animals who are constantly at war with our own groupishness (because of our simultaneous need for autonomy). One of Bion's most interesting concepts described the presence of a dilemma that faces all of us in relation to any group or social system. He hypothesized that each of us has a predisposition to be either more afraid of what he called "engulfment" (fear of loss of personal identity) in a group or "extrusion" (fear of a lack of connectedness) from a group. This intrinsic facet of each of us joins with the circumstances in any particular setting to move us to behave in ways that act upon this dilemma. For example, those of us who fear engulfment more intensely (people like me, for example) may vie for highly differentiated roles in the group such as leader or gatekeeper or scout or scapegoat. Those of us who fear extrusion more intensely may opt for less visible roles such as participant, voter, "ordinary citizen", etc. Bion's idea was that each of us may react upon one or the other side of this dilemma depending on the context, but that the question is always with us of how to "hold" the self, or, put another way, how to assure our personal survival within the life of the collective.

I propose that my fear of engulfment and loss of identity in groups conflicts with group-oriented persons' fear of extrusion and willingness to assume an undifferentiated group mind and that it is this conflict that lies at the center of my difficulties in groups. I further propose that my problems in groups are psychodynamically similar to conflicts I have experienced in the dyadic therapy relationship in which the therapist assumes the role of breast mother.

Random Thoughts

I often think of a line from a poem: "Hearts starve as well as bodies; give us bread but give us roses."

I have asked therapists the following question. They have no answer.

This is what I want to know: Psychoanalysis takes a tremendous investment of time and money. Interestingly, most of the people in analysis are more or less socially adjusted. Obviously, there are people in analysis who are struggling with more than loneliness or social isolation. My question is always: "OK, let's say I have friends. Then what?" Social workers can't answer that. Isn't life what happens after you've had your fill of bread?

What rationalizations will a glutton use?

Perhaps a glutton would say: “People need food. That’s basic biology. You can’t live without food. If you don’t eat, you’ll die. People will die of starvation if they don’t eat.”

What will a medical doctor say to a patient with anorexia?

“People need food. That’s basic biology. You can’t live without food. If you don’t eat, you’ll die. People will die of starvation if they don’t eat.”

If a therapist says: “You need to have friends.” Or “It’s vitally important that you make an effort to have friends,” what is his unconscious agenda? Is he rationalizing his attachment insecurity — or is he talking from the perspective of an independent and mature person about legitimate needs.

Attachment theorists point out that there are conscious internal working models of relationships but also unconscious internal working models of relationships. An internal working model is an internal schema, based on our early attachments in the family, that serves as a road map for our adult attachments. The conscious internal working model is the one that we can verbalize. The unconscious model lies outside our awareness and can differ – sometimes radically – from what we are aware.

Research has shown there are teenagers who have an active social life with lots of friends who, paradoxically, are insecurely attached. Their social relations are defensive: they are kids who have an insecure unconscious attachment to parents (or a disturbed unconscious internal working model) and they experience attachment anxiety that is outside their awareness. They pour themselves into a tightly-knit peer group as a defensive reaction to unconscious attachment insecurity. Perhaps these dynamics are useful in understanding teenage gangs. Many gang members come from disturbed family backgrounds that may have promoted insecure attachment; the gang members defensively form powerful attachments with each other, that is, seemingly secure attachments that belie the members' underlying insecure attachment style.

Are there therapists who come from that cohort, that is to say, individuals who are socially-adjusted, but whose social adjustment is, in reality, a defensive strategy that deceptively disaffirms their attachment insecurity? Might unconscious attachment insecurity affect both my therapist's relationship with me in addition to the way she views my social isolation?

My social withdrawal is defensive but also reflects my capacity for solitary intellectual and aesthetic engagement. That's true of most creative people. Creative individuals must feed their souls as well as feed their social needs. Speaking figuratively, for creatives it's not just about the bread, it's about the roses.

Kernberg's observations about the psychodynamics of dysfunctional groups raise intriguing questions about the problems of a creative individual in groups: a creative person for whom "feeding social needs" is not the be-all and end-all of existence. "The psychology of the group, then, reflects three sets of shared illusions: (1) that the group is composed of individuals who are all equal, thus denying sexual differences and castration anxiety; (2) that the group is self-engendered — that is, as a powerful mother of itself; and (3) that the group itself can repair all narcissistic lesions because *it becomes an "idealized breast mother."*"

Kernberg, O.F., *Ideology, Conflict, and Leadership in Groups and Organizations*.

To what extent does a therapist's view of the therapy dyad reflect unconscious notions of a group ideal in which the client's singular identity is to be expunged and the therapist assumes the role of the "idealized breast mother" who cures through the client's consumption of her feedback ("milk")? My therapist has said: "My technical expertise doesn't really matter. It's whether you can form a relationship with me in which you accept what I say."

When therapists assert that technical expertise does not matter and that they cure through the relationship with the patient I am reminded of something that group theorists, based on Bion's work, call "negative K culture." K (knowledge) in this context is not an intellectual value but refers to what the group knows about itself. Negative K culture refers to the group's lack of self-awareness and is a sign of group dysfunction. See, Hazell, C., *Imaginary Groups*. Broadly speaking, negative K culture in a group is a culture where there is hostility, to a large extent unconscious, towards the generation and maintenance of knowledge (K links). In groups dominated by negative K there is a rejection by group members of complexity, the use of projection to force mental contents into other group members or outsiders, and a tendency to use simplistic clichés or platitudes. (My therapist has used phrases such as "treading water," "steep hill to climb," and "getting thrown under the bus.") Group members will disdain curiosity, conceptual thinking, new ideas, putting thoughts together in new and different ways and gaining insight – in order to ward off the anxiety of thinking. Hazell, C., "The Tavistock Learning Group: Exploration Outside the Traditional Frame." One feature of negative K culture is the "erotization of ignorance," which occurs when a group member starts to publicly think clearly to make explicit K links by getting curious or "putting two and two together." *That individual will be summarily attacked as losing touch with the group or being a snob or "thinking he is better"*

than the others." See Hazell, *Imaginary Groups*. Compare: "You think you are smarter than everybody else." Another feature of negative K culture is theoretical opacity; a group member may seek to explain something in depth and is attacked, "Why do you have to analyze everything?" The only thing that matters in groups dominated by negative K culture is the bond between group members and concomitant efforts to alleviate abandonment anxiety. "*All that matters are the relationships.*" Is my therapist's indifference to theory and technique and her focus on the therapy relationship psychodynamically related to Bion's group concept of negative K?

I have the impression that the underlying agenda of some therapists in their feedback to me is fundamentally: "You want friends. I know you want friends. You need friends. You need to make an effort to have friends."

What do I hear when a therapist says this?

I hear a mother talking to her infant: "You want the breast. I know you want the breast. You need the breast. You need to make an effort to suck on my breast."

Life for me is – and perhaps has been since infancy – what happens after I suck on the breast. The breast has never been my be all and end all. Most people live for the breast. I don't.

For me life is what happens when mommy leaves me in my crib. For me life is what happens when I've "had my fill of bread." I yearn for the roses.

I am an artist, really. Or at least I am an individual with an artistic temperament. Like many artists my imaginative recreation of reality is at times more satisfying than real experience. The writer André Aciman has captured these feelings: "The ideal thing for a writer is when he has

written all day—with minor interruptions thrown in—but needs to head out to a dinner party. He doesn't want to lose his momentum, but he is also eager to meet friends at the dinner. Half-way through dinner, though, he can't wait to get back. Yes, he loves his friends, and company is always fun, but how utterly fantastic to get back before midnight, change clothes, and pick up exactly where he left off at seven. If he's lucky, he may stay up till two in the morning. Something someone said that evening caught his attention. He made a point of remembering it. He'll use it in a sentence he had written earlier that day." To some extent, for Aciman, lived experience, as recreated in his writing, is the ideal rather than the experience itself. For the writer, and for artists in general, all creation is really the re-creation of a tangibly inaccessible past; creation is the expression or transformation of lost time. It is when the world within us exists only as memory, when it is beyond the *material – non iam mater* (no longer mother), as Virgil said – it is then that the artist recreates his world anew, reassembles the pieces, and infuses life into remembered fragments, re-creates life.

Psychoanalytic theory can account for this creative dissociation found in artists. "[Philip Weismann] believed that the future artist, as an infant, had the ability to hallucinate the mother's breast independently of oral needs. According to him the unusual capacities of the artist 'may be traced to the infancy and childhood of the artist wherein we find that he is drawn by the nature of his artistic endowment to preserve (or immortalize) his hallucinated response to the mother's breast independent of his needs gratifications' . . . One major concept of Weismann is the 'dissociative function of the ego' that he substitutes for Kris's concept of regression in the service of the ego. With the aid of this dissociative function, the creative person 'may partially decathect the external object (mother's breast) and hypercathect his imaginative perception of it. He may then further elaborate and synthesize these self-created perceptions as anlagen or precursors of creative activity which must then await full maturation and development of his ego and his

talent for true creative expression.' In simple words, according to Weismann, the child who will become creative has the ability to diverge the energy originally invested in primitive personal objects and to invest it again in creative work." Arieti, S., *Creativity: The Magic Synthesis*.

The psychoanalytic concept of regression in the service of the ego has migrated to mainstream psychology via the concept "openness to experience." Openness to experience is a term that describes an aspect of human personality. Openness involves several facets, or dimensions, including active imagination (fantasy), aesthetic sensitivity, attentiveness to inner feelings, preference for variety, the ability to engage in self-examination, and a fluid style of consciousness that allows the individual to make novel associations between remotely connected ideas. Zimberoff, D. and Hartman, D. "Attachment, Detachment, Nonattachment: Achieving Synthesis" (the concept openness was derived from the concept of 'regression in service of the ego' to mean a loosening of fixed anticipations so that one approaches the objects of his/her experience in different ways, from different angles). See also, McCrae, Robert R., "Creativity, Divergent Thinking, and Openness to Experience."

Creativity, Openness to Experience, and Compatibility of Therapist and Patient

My therapist seems to disdain my free association. Of course, she is not an analyst; she and I are not doing psychoanalysis. But I believe that I require a therapeutic context that permits a more associative approach as well as a therapist who is able to adopt a therapeutic stance of "regressive openness and receptivity." Like many writers I think discursively and by association. I hold many ideas in my mind at once and I strain to express them. I have the personality trait of openness and "research demonstrates that 'openness to experience' is associated with tolerance for regressive experiences such as affects, fantasy and daydreaming, emphasis

on richness of creative imagination and inquisitiveness into the unusual or the subtle nuances of the commonplace, and less use of sustained effort and conventional categories of thought. This state of openness to experience that results from a transient reduction of unconscious defensiveness allows for free association, asking patients to report 'what comes into their heads, even if they think it is unimportant, irrelevant, or non-nonsensical.' Free associations are essential to creativity; because they free the sensitive, fluid, and plastic preconscious system from the rigidity imposed at the conscious and of the symbolic spectrum." Schore, A.N., *Right Brain Psychotherapy*. I require a therapy experience that welcomes and supports my need to express my particular style of thinking.

Some people are genuinely more inclusive in their thinking, more expansive in how they process information. Experiments in personality psychology show that open-minded people process information in different ways and may literally see the world differently from the average person.

Average people cull through incoming information for relevant details, screening out everything else. The problem is, the screened-out information might be useful later, but by then we are slow to realize its significance, to unlearn its irrelevance. This process can be modeled in the laboratory by preexposing participants to seemingly unimportant stimuli that later form the basis of a learning task. For the average person, this preexposure stifles subsequent learning – the critical stimulus has been rendered "irrelevant" and fails to penetrate awareness. Not so, however, for those high in openness, who are less susceptible to "latent inhibition." Open-minded people use a more inclusive mode of thinking – a "leaky" cognitive system, if you will – that lets in information that others filter out. Smillie, L., "Cognition: Openness to Experience: The Gates of the Mind." The ability of a therapist to retain and think about the seemingly irrelevant details that may be in the foreground of a creative

patient's narrative is crucial to her ability to work with that patient's thinking and expression.

Cognitive scientists believe that the overinclusive thinking of open-minded people might be related to a phenomenon known as "mind wandering." Mind-wandering (sometimes referred to as task unrelated thought, or, colloquially, autopilot) is the experience of thoughts not remaining on a single topic for a long period of time, particularly when people are engaged in an attention-demanding task. See Smillie.

Mind wandering seems to have specific relevance to free association. "Mind-wandering is important in understanding how the brain produces what William James called the train of thought and the stream of consciousness. This aspect of mind-wandering research is focused on understanding how the brain generates the spontaneous and relatively unconstrained thoughts that are experienced when the mind wanders. Mind wandering is neurologically-based. One candidate neural mechanism for generating this aspect of experience is a network of regions in the frontal and parietal cortex known as the default network. This network of regions is highly active even when participants are resting with their eyes closed suggesting a role in generating spontaneous internal thoughts. One relatively controversial result is that periods of mind-wandering are associated with increased activation in both the default and executive system a result that implies that mind-wandering may often be goal oriented. See, Spreng, N., et al., "Goal-Congruent Default Network Activity Facilitates Cognitive Control." Engaging the default network (which supports mind wandering) can improve performance. See Spreng.

I see these findings as relevant to free association, which is an oscillating process in which the patient moves back and forth between a regressive phase that features a transient reduction of unconscious defensiveness (allowing for mind wandering or daydreaming) and an adaptive and

synthesizing phase in which the patient actively and logically thinks about his regressed production. In short, the brains of creative patients who exhibit openness to experience may be “hard-wired” for the free association practiced in psychoanalytic therapy, but more, may derive substantial benefit from the practice of free association.

Is my therapist an open-minded individual who is over-inclusive in her thinking, who has a leaky “cognitive” system, that enables her to process the production of an open-minded patient that features mind wandering and a rich narrative text that includes many seemingly irrelevant details – or does her cognition dictate that she filter out the patient’s seeming irrelevancies, thus limiting her ability to learn about her patient?

Another question is the extent to which her work represents a choice that is necessitated by her cognition. One wonders whether the type of therapy work she does provides an adaptive niche for her cognitive style, a cognitive style that filters out the trivial and irrelevant, a cognitive style that seems incompatible with the requirements of psychodynamic work.

Thoughts about Attachment Theory, Feelings of Alienation, a Need for Mirroring, and Loneliness

PATIENT: *I have feelings of alienation.*

THERAPIST: *Let me talk about that from a different perspective. I can show you how what you’re talking about is actually fear of rejection and loneliness. . . . Other people I work with talk about fear of rejection and loneliness.*

I experience feelings of alienation and show a need for mirroring acceptance and twinship, concepts central to the work of psychoanalyst Heinz Kohut, whose work, known as “self psychology,” deals with the psychology of narcissism. Now, my therapist claims that her work is attachment-based. At the first session she said, “My work is informed by

attachment theory, schema therapy, and psychodynamic approaches.” She might be interested to know that attachment theorists have examined the validity and usefulness of central constructs in Kohut's self psychology: selfobject needs for mirroring, idealization, and twinship and avoidance of acknowledging these needs. See, e.g., Shaver, P.R., Banai, B. and Mikulincer, M. “Selfobject Needs in Kohut's Self Psychology.”

Attachment theorists affirm that Kohut's ideas about the origins of selfobject hunger – the need for a mirroring other – resemble specific attachment anxieties: “When parents fail to satisfy selfobject needs by providing mirroring and opportunities for idealization and twinship, the transmuting internalization process is disrupted and pathological narcissism may appear. The sense of self-cohesion will not develop, and powerful archaic needs for admiration, powerful others, and twinship experiences will remain. In Kohut's words, 'the psyche continues to cling to a vaguely delimited image of absolute perfection.' That is, the person retains a chronic, archaic 'hunger' for selfobject experiences, and his or her behavior is characterized by a continuing search for satisfaction of unmet selfobject needs. . . .”

Kohut's broad ideas about hunger for selfobject provisions and avoidance of selfobject needs in adulthood as reactions to the deprivation of selfobject provisions during childhood resemble Fraley and Shaver's hypothesis about two different psychological reactions to deprivation of attachment provisions.” Banai, E., Mikulincer, M., Shaver, P. “Selfobject” Needs in Kohut's Self Psychology: Links With Attachment, Self-Cohesion, Affect Regulation, and Adjustment.”

My therapist has said to me: “You feel different from other people and you feel that you need people who mirror you (or that you feel alienated from people) because if they are not like you, they will reject you.” The therapist's interpretation seems to imply that I have feelings of shame about being different that triggers my approach avoidance. That's not

what I feel. I feel frustration, not shame. I feel I need a mirror image object, and when I don't experience that mirror image object – that is, someone like me – I feel alien. A coworker once made a keen observation about me: "You only like people who remind you of yourself."

What I experience consciously is not the need for a friend but a "selfobject" – a need for affirmation, validation, a sense of selfsameness with another who offers himself for identification for the purpose of enhancing growth. The conscious feeling I experience is not loneliness but "selfobject hunger." By analogy, when a person with hypoglycemia asks for a glass of orange juice – it is not to satisfy his alimentary needs (thirst), but to cure a defect in the self.

A paraphrase of an observation about anorexics, oddly, can be applied to my disinterest in conventional social relations and my concern for an identity-affirming other: "The Other that matters for me is the Other of the reflected mirror image, the Imaginary Other, the idealized similar one, the Other as an ideal projection of my own personality elevated to the dignity of an icon, the Other as a reflected embodiment of the Ideal Ego, as a narcissistic double of the subject, the idealized Other of the reflected image of the self." Recalcati, M. "Separation and Refusal: Some Considerations On The Anorexic Choice."

Attachment theorists contemplate the possibility that "selfobject hunger" might not be attachment based – analogous to the fact that a hypoglycemic's need for glucose is not alimentary based. Perhaps my desire for connection with a mirror image other has nothing to do with conventional feelings of loneliness and a desire for comradeship? "[Revised attachment theory] should no longer include the implicit assumption that all romantic, or couple, relationships are attachment relationships. Although the original theory did not explicitly claim that all coupled partners were attached in the technical sense, Hazan and Shaver did not really address the possibility that some partners were attached and

some were not, nor did they offer a method for making this distinction empirically. Over the last few years, researchers have tackled the problem and provided preliminary but useful methods that should be included in future studies." Fraley, C., Shaver, P., "Adult Romantic Attachment: Theoretical Developments, Emerging Controversies, and Unanswered Questions."

Attachment theory elucidates attachment, that is, the biologically-driven bond that develops between mother and infant as well as derivatives of that original bond in the form of adult attachments such as friendships or romantic couplings. But not all human relationships constitute "attachments." "Each theory has boundaries and attachment theory is no exception. In fairness to Bowlby, he was not attempting to explain every aspect of or type of close relationship. His aim was simply to explain the structure and functions of attachment . . ." Shaver, P.R., "Attachment as an Organizational Framework for Research on Close Relationships."

Attachment theory seems to consider the possibility that the self-selfobject relationship described by Kohut – that is, the relationship between a narcissist and an idealized Other – does not constitute an "attachment" in a technical sense. Put another way, self-selfobject relationships should not be seen as derivatives of the mother-infant bond, rather these relationships should be viewed as a derivative of *deficits* in the mother-infant relationship. Friendship will mitigate feelings of loneliness owing to the lack of a comrade. But friendship will not allay the narcissistic hunger associated with the absence of an identity-affirming other. When I speak of narcissistic hunger I refer to an *inner* sense of loneliness, not to the objective situation of being deprived of external companionship. I am referring to the inner sense of loneliness – the sense of being alone regardless of external circumstances, of feeling lonely even when among other people. This state of internal loneliness, in my case, springs from disturbances in my earliest interactions with my mother and inadequacies

in her mirroring of my emerging self. Cf., Klein, M. "On the Sense of Loneliness."

Therapy Session: June 6, 2018

At the outset of the session I said to the therapist, "I had the feeling last time that you were feeling overwhelmed by me. My sense that you felt overwhelmed last week was triggered by your statement at that session: 'You think you're smarter than everybody else.'"

I had the subjective impression that what I discussed the previous week had psychologically threatened the therapist, and that at this session she became defensive when I said she had seemed "overwhelmed." When I recounted my recollection that the therapist had said, "You think you're smarter than everybody else," she replied: "That's not something I would have said." Concerning my statement at this session that she seemed to have been overwhelmed the previous week, she said: "A person can't read minds." "I wasn't feeling overwhelmed." "Let's look at how your impressions of other people came into play in your workplace relationships." I began to experience discomfort with the therapist's persistence and at one point I said, "I don't want to spend the entire hour talking about this." I had the sense that my observations about her inner mental state the previous week unnerved her.

Was there a more productive approach the therapist could have taken? Perhaps she could have asked: "Were there times in your relationship with your mother that you felt you overwhelmed her emotionally?" "Did you feel emotionally constricted in your relationship with your mother to the point that you felt you needed to suppress your feelings around her?" "Did you feel that if you aroused negative emotions in your mother she would punish or reject you?"

In fact, it's been recognized that a particular parenting style promotes a dismissive avoidant attachment style in children, that is, a type of attachment style in which the individual scorns relationships and relies instead on pathological self-sufficiency: "Parents of children with an avoidant attachment tend to be emotionally unavailable or unresponsive

to them a good deal of the time. They disregard or ignore their children's needs, and can be especially rejecting when their child is hurt or sick. These parents also discourage crying and encourage premature independence in their children.

In response, the avoidant attached child learns early in life to suppress the natural desire to seek out a parent for comfort when frightened, distressed, or in pain. Attachment researcher Jude Cassidy describes how these children cope: "During many frustrating and painful interactions with rejecting attachment figures, they have learned that acknowledging and displaying distress leads to rejection or punishment." By not crying or outwardly expressing their feelings, they are often able to partially gratify at least one of their attachment needs, that of remaining physically close to a parent.

Children identified as having an avoidant attachment with a parent tend to disconnect from their bodily needs. Some of these children learn to rely heavily on self-soothing, self-nurturing behaviors. They develop a pseudo-independent orientation to life and maintain the illusion that they can take complete care of themselves. As a result, they have little desire or motivation to seek out other people for help or support."

Is my act of writing letters about my therapy sessions, in part, a form of self-soothing or self-nurturing that I turn to because I feel I cannot share my feelings and perceptions with my therapist? Does this therapist permit me to have negative feelings about her? At a deep, unconscious level does the therapist interpret my negative comments about her as the symbolic biting behavior of the infant feeding at his mother's breast?

POSSIBLE THERAPIST ANXIETY IN RELATION TO ME

It is recognized that difficult or triggering clients can arouse anxiety in a therapist. Shamoona, Z.A., Lappan, S., Blow, A.J. "Managing Anxiety: A

Therapist Common Factor.” *Contemporary Family Therapy*, 39(1): 43-53; (March 2017). The authors propose that effective therapists need to be able to manage their emotions, especially their anxiety, in order to truly help their clients. The failure to do this can lead to break downs in the alliance and the flow of therapy, and these deleterious effects can be prevented when therapists actively navigate their internal states through self-awareness and ongoing introspection.

Were there signs of anxiety in the therapist's response to me?

The therapist denied having said at the previous session, “You think you're smarter than everybody else.” She said, “That's not something I would say.” But was there in fact a discrepancy between what the therapist said she felt and what she actually felt? Can a client be sensitive to such discrepancies in a therapist?

Interestingly, several sessions ago, the therapist said in another context, “Are you always right?”

Let's look at those two statements:

“You think you're smarter than everybody else.”

“Are you always right?”

Notably, both statements are black and white statements or “all or nothing” statements, suggestive of splitting. It is recognized that individuals can regress to a state of splitting in response to anxiety, that is, in response to feelings of being threatened. Anxiety causes individuals to revert to paranoid-schizoid thinking which defends the self by the dichotomous splitting of ideas into *good and bad (or all or nothing)*, thereby holding onto good thoughts and feelings and projecting out the bad. Unconscious splitting avoids the troubling nature of what learning may

actually involve, so that a lack of appreciation of the complexity of the whole object vitiates the emergence of complex solutions and promotes the emergence of simplistic “quick fixes.” Hirschhorn, L. *The Workplace Within: Psychodynamics of Organizational Life*.

I am reminded of an interaction I had in therapy in about July 1994, when I was in treatment with Dimitrios Georgopoulos, M.D. Dr. Georgopoulos responded angrily after I seemed to contradict him by saying, “You’re changing the focus.” He said, “**Everybody** has to agree with you? **Nobody** can disagree with you?” The therapist responded with what appeared to be “all or nothing” thinking.

Is it possible that my resistance in therapy triggers anxiety in the therapist, which arouses a paranoid response, namely, a regression to “all or nothing” thinking? Does my failure in group situations, such as the workplace, to relinquish my individual identity and assume a group identity trigger retaliatory aggression by group members? I don’t know. It’s only a tentative idea.

IS IT POSSIBLE FOR A THERAPY CLIENT TO READ MINDS?

The simple answer is no. We cannot read another person's mind. But several caveats need to be stated.

Some clients are recognized to be psychologically minded. Psychological mindedness refers to a person's capacity for self-examination, self-reflection, introspection and personal insight. It includes an ability to recognize meanings that underlie overt words and actions, to appreciate emotional nuance and complexity, to recognize the links between past and present, and insight into one's own **and others' motives and intentions**. Psychologically minded people have above average insight into mental life.

Some definitions of psychological mindedness relate solely to the self, "a person's ability to see relationships among thoughts, feelings, and actions with the goal of learning the meanings and causes of his experiences and behaviors." The concept has been expanded beyond self-focus, as involving "... both self-understanding and an interest in the motivation and behavior of others".

The writings of Harold Searles, M.D. have centered on the honesty required of a therapist to acknowledge the patient's insights about the therapist's internal mental states. Searles, who happened to be one of the most eminent psychiatrists of the twentieth century, wrote that he has very regularly been able to find some real basis in himself for those qualities which his patients - all his patients, whether the individual patient be more prominently paranoid, or obsessive-compulsive, or hysterical, and so on - project upon him. It appears that all patients, not merely those with chiefly paranoid adjustments, have the ability to "read the unconscious" of the therapist. This process of reading the unconscious of another person is based, after all, upon nothing more occult than an alertness to minor variations in the other person's posture, facial expression, vocal tone, and so on, of which the other person himself is unaware. All neurotic and psychotic patients, because of their need to adapt themselves to the feelings of the other person, have had to learn as children - usually in association with painfully unpredictable parents - to be alert to such nuances of behavior on the part of the other person.

Albert Rothenberg, M.D. found that some patients were unusually sensitive to the implicit messages contained in others' communications, a sensitivity that resulted from these patients' adaptation to a disturbed developmental environment in which there were often remarkable discrepancies between what family members said they felt and what they actually felt. Rothenberg, A. *Creativity and Madness at 12* (Baltimore: The Johns Hopkins University Press, 1990).

Park and Imboden found that some clients have an inborn talent and need to discern the feelings and motivations of others (intuitive brilliance); the trait was innate and had positive value, and should properly be termed a gift. Much as one would refer to the mathematically gifted person or the musically gifted person, the authors concluded that some clients have a cognitive giftedness in the area of self- and other-perceptiveness called “personal intelligence.” The authors recommended validating, when appropriate, the following characteristics of such clients: exceptional personal intelligence; and the absolute right to experience their innate capacity for freely enjoying their feelings, their perceptions, and thoughts (including thoughts about the therapist). Park, L.C. and Imboden, J.B., et al. “Giftedness and psychological abuse in borderline personality disorder: Their relevance to genesis and treatment.”

Is there any basis to this therapist's assertion that I could not possibly have accurately read her internal mental state of anxiety and perceived threat? Probably not. Indeed, according to Searles and Rothenberg, a patient who grew up in an disturbed family environment with “painfully unpredictable parents” is exactly the type of client who would be most likely be able to read a therapist's internal mental states. When a therapist denies a gifted client's intuitive abilities, is she not, in fact, invalidating the client – an action that is anti-therapeutic?

DOES THE THERAPIST ENGAGE IN PREMATURE CLOSURE?

“Premature closure is a maladaptive, pre- and unconscious, inappropriate defensive maneuver that a counselor may use when overwhelmed by the professional challenge. Expressions of premature closure can be an inability to handle the client's intense emotions or an inability to enter or stay in the experiential world of the client.” Skovholt, T.M. and Rønnestad, M.H. “Struggles of the Novice Counselor.” *Journal of Career Development*, 30(1): 45-58 (2003).

At my first session with this therapist I reported that I believed my mother was a negligent mother. *That was my experiential world.* Instead of delving into my perception of maternal negligence, the therapist chimed in at once, "I wouldn't say your mother was negligent." How would the therapist be able to offer an opinion on that issue after knowing me for only a half hour?

At this session I stated the following: "I have been thinking about something relating to my maternal grandfather - my grandmother's husband. He died in the great flu epidemic of 1918, when my mother was three years old. I'm attracted to the tentative idea that he might have been an exploitative person. He was originally from Poland but had lived in the United States for a period. Then he went back to Poland, apparently to look for a wife. They got married and moved together to the United States in 1910. She left her entire family behind and never saw them again. My grandmother was 18 years old. And, you know, I'm thinking, he might have exploited my grandmother. Maybe he sold my grandmother a bill of goods about how wonderful America was and what a wonderful life they would have together in the United States. Maybe he took advantage of her. (If this were so, the relationship would uncannily parallel the relationship between my sister and her late husband, who was an unusually interpersonally exploitative person, an individual who convinced my sister that he was "a perfect person who had no flaws" and that he was the child of a "perfect mother.")

The idea that my maternal grandfather was an interpersonally exploitative individual is a tantalizing one because that view of him is consistent with a narcissistic family dynamic that may have been transmitted through the generations. See, e.g., Beatson, J.A. "Long-term psychotherapy in borderline and narcissistic disorders: when is it necessary?" Aust N Z J Psychiatry., 29(4):591-7 (Dec. 1995) (Patients with borderline and narcissistic pathology who have sustained severe early developmental trauma will often require long-term psychotherapeutic treatment to

achieve lasting psychological change. Such treatment is necessary for the relief of suffering in the patients, and may contribute to the alleviation or prevention of the intergenerational transmission of these disorders).

At once the therapist responded to my narrative, "I wouldn't say he was exploitive. Maybe he was just an optimist. Maybe he filled your grandmother with optimistic ideas about a better life in America."

My subjective impression of the therapist is that she has a persistent "Pollyanna" quality that forces her to turn away from the darker edges of my experiences and emotional problems, to wit, "Your mother wasn't negligent." "Your grandfather wasn't exploitive." "You can make friends if you try; you simply need to take risks with people."

Note the possible projective aspect of the therapist's statement, "Maybe he was just an optimist. Maybe he filled your grandmother with optimistic ideas about a better life in America." Is the therapist herself an optimistic individual who is trying to get me to internalize her overly-optimistic view of my reality as well as get me to turn away from delving into the darker side of my experiential world? One wonders.

The fact is that in attachment theory, the best evidence for the actual relationship between the patient and his attachment figures – such as a negligent mother or an exploitive grandfather – is the client's *unconscious internal working model*, that is, the unconscious internal schema of interpersonal expectations and fears that an individual forms in response to his lived experience with early attachment figures. According to theory, the unconscious internal working model is a kind of "black box (or flight data recorder)" of the actual lived relationship between the patient and his early attachment figures in contrast to the *conscious internal working model* that may be based on defensive distortions. The unconscious internal working model is the "best evidence" of the nature of the relationship between the client and his early attachment figures, according to theory. The therapist's idle, optimistic speculation about my

attachment figures is as meaningless as saying – before analysis of the black box evidence in an airplane crash investigation – "well, maybe the pilot wasn't negligent, maybe he did everything he was supposed to do." Those are just empty words. It's what an analysis of the black box data tells you that is definitive; notions that are simply need-satisfying to the airline (or therapist) have no value.

"Bowlby writes that 'the particular form that a person's working models take are a fair reflection of the types of experience he has had in his relationships with attachment figures.' This is a straightforward claim that working model representations constitute a relatively accurate reflection of actual events. However, Bowlby also allows for the possibility of multiple internal working models, one relatively accessible to consciousness and one 'relatively or completely unconscious', that may conflict with each other. It is clear that Bowlby views the unconscious working model as an accurate representation of actual events in contrast to the conscious working model which is often a distorted product of defense." Eagle, M.N. *Attachment and Psychoanalysis Theory, Research, and Clinical Implications*.

In light of attachment theory, does it make sense for a therapist to simply speculate that the client's mother was not negligent without the therapist having a depth understanding of the client's unconscious internal working model, which will have encrypted the lived relationship between the client and his mother, including mother's possible inadequacies? Does it make sense for a therapist to simply speculate that the client's grandfather was not an exploitive individual without the therapist having a depth understanding of the client's unconscious internal working model, which may have encrypted the issues of intergenerational transmission of narcissistic or exploitive family dynamics? See, e.g., Beatson, J.A. "Long-term psychotherapy in borderline and narcissistic disorders: when is it necessary?" *Aust N Z J Psychiatry.*, 29(4):591-7 (Dec.

1995) (borderline and narcissistic disorders are transmitted intergenerationally).

John Bowlby, M.D. himself – the father of attachment theory – strongly emphasized the importance of the therapist in helping the patient to recognize and accept the dark side of his experiences. Bowlby said: “So there is a reason why I think it's – the greatest reason to assist a patient discover their own past and also, of course, to realize, to recognize, how it comes about how they cannot initially come to, can't do it, or don't want to do it. Either it's too painful – no one wants to think that our mother never wanted them, and always really rejected them, it's a very painful, very, very painful situation for anyone to find themselves in. *Yet if it's true, it's true, and they are going to be better off in the future if they recognize that that is what did happen.*” John Bowlby on Attachment and Loss, videotaped presentation, 1984.

What is a therapist's hidden agenda in offering mere speculations that seem to consistently rationalize the possible empathic failures of the client's attachment figures? In trauma work, isn't the pertinent issue the nature of the client's psychological injury – which speaks for itself – and not mere speculation about historical facts relating to the source of the injury? Analogy: a driver was in a bad car accident, was severely injured, and has been taken to the emergency room. The patient's injury (trauma) speaks for itself. Does it make sense for the emergency room doctor to speculate about whether the other driver was negligent; whether the other driver was an exploitative individual who didn't care if he drove while intoxicated? Aren't these questions, in fact, moral issues that are irrelevant to the trauma? Does trauma, at least as it relates to the survivor, even have a moral dimension? In working with a client who has serious character pathology aren't the following questions the only pertinent questions from an attachment theory perspective: Does this client show the recognized consequences of maternal negligence? Does this client show the recognized consequences of an exploitative family, including

possible intergenerational transmission of narcissistic family dynamics? Again: What is a therapist's hidden agenda in offering mere speculation that seems to consistently rationalize the possible empathic failures of the client's attachment figures? Why would such reassuring speculations be need satisfying to a therapist? Why would a therapist who claims to be an attachment therapist deny the clear implications of possible evidence of the client's unconscious internal working model?

INTUITIVE GIFTEDNESS AND THE NARCISSISTIC NEED FOR TWINSHIP, IDEALIZATION AND MIRRORING: “*A young man whom the superiors had their eyes on . . .*”

At another point in the session I related the following: “You were talking about my need to take risks with people and I want to talk about that. This also relates to the issue of intuition. I don’t like most people. I wouldn’t be interested in most people for friends. I mean there are people I chat with in my apartment building and sometimes I wish I didn’t. I talk to most people out of politeness. I’m not really interested in talking to them or being their friend. If you talk to some people they get the idea that they want to be your regular chat buddy, and I hate that. I don’t like having to chat with people I would prefer not chatting with.

So, anyway, this goes back 15 years to the year 2003. There was a new guy in my building. His name was Brad Dolinsky. I didn’t know anything about him. But I was curious about him. He wore Army fatigues sometimes. [My father had served in the U.S. Army in World War II and spoke often about his military experiences.] Once he gave some cookies to the guy at the front desk. In my mind, I thought of him as “the cookie guy.” He was somebody I would be interested in talking to. I asked the front desk manager who he was. She said, “That’s Brad Dolinsky. He’s a doctor. He’s doing his residency at Walter Reed. He’s very smart. *There are people high up in his field who have their eye on him.*” I thought, “I knew it! I could tell there was something different about that guy.”

So I researched the guy on the Internet. And I learned that there were several technical papers that he had co-authored – and he was still only a resident. This confirmed for me that I can read people.

I told my therapist (Dr. Israel Bash) about him. Dr. Bash was always saying I should make friends. I told Dr. Bash that Brad Dolinsky was somebody who could be a friend for me. When I told her he was a medical doctor, she said, “Put that out of your mind. No medical doctor would be friends with you. You need to be friends with people at your level (and she didn’t mean that in a good way!).” He’s about 25 years younger than me.

So about taking risks. We used to have a roof deck in my building. It’s closed now. Brad Dolinsky used to sunbathe on the roof. I always thought that was odd, that a medical doctor would sunbathe. And sometimes he would get red as a lobster. Anyway, one day he came up to the roof and laid down on a lounge chair. He was right across from me. I was thinking of introducing myself. But I didn’t have the nerve. So I could have introduced myself, and maybe we would have chatted. And maybe when he saw me he would have waved to me and said, Hi. But that would have been it. We would never have become friends. He lives in Washington State now. He’s married and has a couple of kids.”

Was my unusual reaction to Brad Dolinsky an outcome of my possible intuitive giftedness, an uncanny skill that enables me to sense another individual's ability to gratify my need for self-sameness – that is, gratify my need for narcissistic mirroring?

The following observation in the above narrative is significant: “There are people high up in his field who have their eye on him.”

Related Anecdotes:

In the fall of 1973 I took an introductory course in meteorology at Penn State. It was my junior year. The class was a large lecture-hall type class. Joel Myers, Ph.D., President of AccuWeather, was the instructor. Myers is a nationally-prominent meteorologist. He served on the faculty of Penn State from 1964 until 1981 as instructor, lecturer and assistant professor and has taught weather forecasting to approximately 17% of all practicing meteorologists in the United States upon retirement from active teaching in 1981.

The meteorology course I took had a lab component, where students broke up into small groups.

One day Myers asked a question in class. I appeared to be the only student in the lecture hall to raise his hand. I gave the correct answer.

Weeks passed.

One day I was walking through the hall in the Earth Sciences building where Myers' office was located. Myers saw me. As I approached, he said, "Hello, Gary." How did he know my name? Why would he know my name?

My only thought is that my answer to his question in class weeks earlier had triggered his curiosity, and he asked the lab instructor who I was.

People take notice: "*There are people high up in his field who have their eye on him.*"

Following my graduation from college I got a job as an editorial assistant at The Franklin Institute in Philadelphia.

In March 1976, when I was 22 years old, the Vice President of the Franklin Institute (Alec Peters) sent a note to my supervisor (Bruce H. Kleinstein, Ph.D., J.D.) saying that he should put “an annotation” in my personnel file stating that I was doing a good job. I had *absolutely nothing* to do with Alec Peters! Why did he do that? Why did the Vice-President of the Franklin Institute take an interest in me?

“There are people high up in his field who have their eye on him.”

My autobiographical book *Significant Moments* includes the following pertinent passage:

Joseph himself would scarcely have imagined that . . .

Hermann Hesse, *Magister Ludi: The Glass Bead Game.*

. . . his precocious . . .

Charles Dickens, *Dombey and Son.*

. . . appointment to Mariafels represented a special distinction and . . .

Hermann Hesse, *Magister Ludi: The Glass Bead Game.*

. . . one of the major steps in a candidate’s progress . . .

J. Moussaieff Masson, *Final Analysis: The Making and Unmaking of a Psychoanalyst.*

. . . but he was after all a good deal wiser about such matters nowadays and could plainly read the significance of his summons in the attitude and conduct of his fellow students. Of course, he had belonged for some time to the innermost circle within the elite of the Glass Bead Game players, but now the unusual assignment marked him to all and sundry as *a young man whom the superiors had their eyes on and whom they intended to employ.*

Hermann Hesse, *Magister Ludi: The Glass Bead Game.*

What is the significance of an interplay between my possible intuitive giftedness and my narcissistic need for twinship, idealization and mirroring? Is there an interplay between my sense of alienation from others who do not mirror me and my uncanny ability to sense certain persons' shared self-sameness?

Therapy Session: June 19, 2018

To know and not to know, to be conscious of complete truthfulness while telling carefully constructed lies, to hold simultaneously two opinions which canceled out, knowing them to be contradictory and believing both . . . to forget, then to draw it back into the memory again at the moment when it was needed, and then promptly to forget it again, and above all to apply the same process to the process itself . . . consciously to induce unconsciousness, and then once again to become unconscious of the act of hypnosis you had just performed. Even to understand the word 'doublethink' involved the use of doublethink. Emmanuel Goldstein, *The Theory and Practice of Oligarchical Collectivism*.

—George Orwell, 1984.

The Ministry of Peace concerns itself with war, the Ministry of Truth with lies, the Ministry of Love with torture and the Ministry of Plenty with starvation. These contradictions are not accidental, nor do they result from ordinary hypocrisy: they are deliberate exercises in doublethink. Emmanuel Goldstein, *The Theory and Practice of Oligarchical Collectivism*.

—George Orwell, 1984.

I began the session with the following narrative:

PATIENT: So, at the end of the last session you asked me how I was feeling about the session. I said I felt good. I might have said that I might not even write a letter about the session; I felt that good at the end of the session. But when I got home the same pattern emerged as in the past. I go home and I start thinking about the things you said, and I begin to see problems in your comments. Things you said at the session begin to make no sense to me. I experience painful feelings of confusion. Then I begin working on a letter to write about what you've talked about, a kind of critical analysis of what you said. Writing these letters resolves my confusion and my mental state improves after I write the letter.

THERAPIST: Do you have any thoughts about why that happens?

PATIENT: Well, I think it might have something to do with my relationship with my mother. Perhaps when I am with you it's like I'm

with my mother and I enjoy her comforting presence. But then I leave you, and maybe it's as if I have separated from my mother and I begin to feel distress. There's also the issue of context. When I am with you and we are interacting, there's a moment-by-moment give and take. I am in the moment. What we talk about occurs in fragments. But when I leave I begin to put everything together and I begin to look at the context. I see the whole picture and a new image appears. I begin to see our interaction in a new light. After I leave I focus on the context and the patterns I begin to see in the session.

And then, also, I have a theory. And it's rooted in attachment theory. In attachment theory there's the idea that a person doesn't just have one internal working model. He can have several internal working models. And I'm thinking maybe my feelings about you when I am with you are determined by one internal working model, and when I leave my feelings about you are determined by a different internal working model. It's a working model based on the absent mother. It's as if I have a "present mother" internal working model and an "absent mother" working model.

THERAPIST: That's an interesting theory.

PATIENT: But I have other thoughts. We all have ambivalent feelings about people, even people we care deeply for. We have positive feelings and negative feelings about everybody in our lives, I think. So we all have split feelings. I think most people are not aware of that. Most people, if they like someone, or care for that person, they're not aware of the unconscious negative feelings. But those negative feelings are there, with everybody. What I think is possible for me is that I have access to those negative feelings. That is to say, I am aware of my ambivalence. But I can tolerate those negative feelings consciously. I can tolerate my ambivalence. So maybe it is that what makes me different from other people is not that I have ambivalent feelings about other people, but simply the fact that, unlike other people, I am aware of my ambivalence with people and I can talk about it and live with it.

(It's like when I was seeing Dr. Palombo, I idealized him but I was aware

of also despising him. When I idealize somebody, it's not like the idealization I read about in the literature. What I read is that people who idealize somebody think that person is perfect with no flaws, the ideal person. I don't idealize like that. When I idealize somebody – yes, that feeling of the ideal is strongly present, but I appreciate the individual's flaws and limitations. My idealization doesn't block my negative feelings or an appreciation of the other person's limitations. It's as if my idealization doesn't totally destroy my reality testing. I don't know what that means. I've never read about that kind of idealization in the literature. I think that if I had had a computer when I was seeing Dr. Palombo back in 1990 I would have written letters about him too. That's what I think.)

COMMENT ABOUT KLEINIAN THEORY

In her book *Handbook of Dynamic Psychotherapy for Higher Level Personality Pathology* the psychoanalyst Eve Caligor, M.D. explains that in the more developmentally advanced depressive position, the subject begins to tolerate ambivalence, bringing an awareness of hostility toward and from beloved objects. Awareness of ambivalence leads initially to depression, pain, loss, guilt, and remorse and the wish to make reparation.

Ultimately, the individual takes responsibility for and mourns the damage he has done to his objects in fantasy as he comes to tolerate emotional awareness of the loss of ideal images of himself and his objects (Segal 1964). Working through depressive anxieties enables the individual to take responsibility for his own destructive, aggressive, and sexual impulses while tolerating awareness of these impulses in others; to establish mutually dependent relationships; and to feel love and concern for others, who are experienced as separate and complex. Further, the capacity to experience others as separate is closely tied to the capacity for symbolic thought (Spillius 1994). Klein contrasts the depressive position with the more “primitive” paranoid schizoid position (Klein 1946), in which ambivalence is not tolerated, splitting predominates, and positive, loving and negative, aggressive object relations are kept apart. Where the central anxieties of the depressive position have to do with guilt over

one's own potential to be destructive or hurtful, anxieties of the paranoid schizoid position are experienced as coming toward, rather than stemming from, the subject, and have to do with fears of annihilation. In the paranoid schizoid position, ego boundaries are relatively porous and objects are controlled; thought is concrete and omnipotent.

Dr. Caligor's observations may offer insight about my split feelings about my therapist. According to theory, a patient may use paranoid anxiety as a defense against depressive anxiety and, alternatively, use depressive anxiety as a defense against paranoid anxiety. I am struck by my observation in the above narrative about my perceiving my therapy sessions as a collection of fragments and then later seeing the session as a "whole object" when I leave the session, with the emergence of a contextual framework. Paranoid anxiety relates to seeing the mother in fragments (or part objects) without an appreciation of the mother as a whole, that is, without an appreciation of how the part objects come together in a contextual framework. Whereas the developmentally more advanced position of depressive anxiety is associated with the perception of the mother as a whole object; the individual places the fragments or part objects of mother into a contextual framework. I don't have the technical expertise to discuss these issues in depth, but I believe that Kleinian positions may offer insight into my split perception of the therapist as either emotionally satisfying or persecutory.

What is not clear to me is why my positive feelings about the therapist are associated with my fragmented moment-to-moment perceptions at the session, while my negative feelings about the therapist emerge after I leave; and then, later as the negative feelings become strong I am motivated to write a critical analysis of the session that emphasizes context, the completion of which letter is associated with an improved mental state.

Somehow this progression seems related to Philip Weisman's theory about the potentially creative infant, who is putatively able to hallucinate the mother's breast in the mother's absence, a precursor of creative activity

in the adult. What I imagine Weisman is saying is that the potentially creative infant has positive feelings in mother's presence; negative feelings emerge in the mother's absence, and the infant proceeds to use a dissociative process to mitigate his negative feelings through use of the forerunners of creative imagination.

Said progression seems consistent with Hanna Segal's theory that creativity emerges out of the depressive position. The concept of the depressive position, as originally described by Klein, allows for the possibility to discuss the idea of an internal creative world. Betty, N.S. "Creativity: The Adaptive Aspects of Insecure Attachment." Essentially, the wish to restore the whole loved object, which the individual believes has been lost because of his own attacks, induces guilt that fuels the wish to make reparations. *Id.* "This wish to restore and re-create is the basis of later sublimation and creativity (Segal)." *Id.* According to Segal, as long as depressive anxiety can be tolerated by the ego and the sense of psychic reality retained, depressive fantasies stimulate the wish to repair and restore. *Id.* Importantly, Segal made the following critical observation about the link between depressive anxiety and creativity: "I have quoted [the novelist, Marcel] Proust at length because he reveals such an acute awareness of what I believe is present in the unconscious of all artists: namely, that all creation is really a re-creation of a once loved and once whole, but now lost and ruined object, a ruined internal world and self. It is when the world within us is destroyed, when it is dead and loveless, when our loved ones are in fragments, and we ourselves are in helpless despair, it is then that we must recreate our world anew, reassemble the pieces, infuse life into dead fragments, re-create life. . . . [T]he wish to create is rooted in the depressive position and the capacity to create depends on a successful working through of it[.]" Segal, H. "A Psychoanalytic Approach to Aesthetics."

Aren't Caligor, Weisman, and Segal talking about the same processes? I don't know. But I do believe that an assessment of the role of letter writing in my psychic life – an activity that involves both integration at an intellectual level as well as moderation of ambivalent feelings about my

therapist – is an important issue that may have diagnostic significance as it relates to my level of integration of internal object relations, that is, my level of ego functioning.

Dr. Caligor writes: "We link the progressive integration of internal object relations and structural change in higher level personality pathology to the working through of conflicts characteristic of the “depressive position” (Klein 1935). As *depressive conflicts are worked through and ambivalence is tolerated*, we see increased integration of internal object relations and decreased personality rigidity (emphasis added)."

1. The therapist said that my observations about her in my letters were projections.

(a) Why would it matter if my observations are projections? It's a matter of interest how I perceive or image the therapist, distortions and all. My perceptions of the therapist – however biased or distorted – are useful indicators of my internal working models and how I perceive and interact with people. A patient's transference is irrationally motivated, biased – but analyzable; it provides a window into the patient's inner world. When an artist paints a portrait of a subject the interest of the portrait lies to an extent in the fact that it is not an objective photographic representation: the portrait expresses the artist's subjective impression of the subject. That subjective impression of the model by an artist is an analyzable production by the artist that reveals aspects of his own personality even as it poses as a representation of the model. Keep in mind, we remember Rembrandt and his subjective impressions of his models as encapsulated in his portraits; we do not remember Rembrandt's models. My letters – my verbal portraits – are fundamentally about me and my perceptions of others; the letters are not objective reports about people in my life, including the therapist.

Melanie Klein laid great emphasis on the constructive role to be played by interpreting the negative transference, that is, the patient's negative feelings about the therapist. Jacques Lacan followed her theoretical lead in seeing "the projection of what Melanie Klein calls bad internal objects" as

key to "the negative transference that is the initial knot of the analytic drama."

W. R. D. Fairbairn was also more interested in the negative than the positive transference, which he saw as a key to the repetition and exposure of unconscious attachments to internalized bad objects. In his wake, object relations theorists have tended to stress the positive results that can emerge from working with the negative transference.

(b.) I compared my behavior of writing letters about my therapist to the activity of a novelist who uses someone in his environment as a model for a character in a book he is writing: a character that contains factual elements merged with the novelist's subjective gloss. In response to my statement, the therapist might have said: "I am not a character in a book." I found the comment interesting. She was stating a fact. That is, she seemed to defend against my creative elaborations with a statement of a fact, ignoring my activity of creative elaboration. I will return to this point in paragraph (h.)

(c) In projective testing, such as the Rorschach, everything the test subject says is a projection. How the test subject interprets or perceives the ink blots reveals aspects of the subject's inner world. Why would the therapist not be interested in my perceptions of her – distortions and all – and how those perceptions serve as a window into my inner world? Is it that the therapist has no interest in my inner world, my subjective experience?

(d) At one point the therapist seemed to express concern about my not discussing my observations about her in the sessions themselves, allowing her to comment on my perceptions, possibly to "reality check" my perceptions of her. Why would a patient need to do that? The therapist's statement suggests that I am only allowed to have "approved" thoughts about her. Is she saying that I am not allowed to have any opinions about her that conflict with her self-image? In the political realm, isn't that the situation that prevails in totalitarian states: newspapers must submit their articles to the government censors before publication so that only state-approved reports or commentary is published? Another thought: When

The Washington Post sends out a restaurant critic to a local restaurant, is the restaurant given a chance to read the review before it is published with the right to comment on the review? That's preposterous.

Restaurants know that newspapers have a right to fair comment and criticism – they have a right to publish opinions about the restaurant that conflict with the restaurant's view of itself, even highly negative opinions. The therapist's attitude toward my observations about her in my letters seems consistent with her response to my perceptions of third parties. When I told her that I thought my mother was negligent, she proceeded to offer her contrary opinion – as if I was then supposed to adopt her officially approved opinion. When I told her that I thought my grandfather might have been exploitative, she proceeded to offer her contrary opinion – as if I was then supposed to adopt her officially approved opinion. It's as if the subtext of the therapist's interaction with me is that I must adopt her world view. I may have no opinions that do not meet with her view of herself and the world. The psychoanalyst Leonard Shengold has written that the purpose of therapy is to promote the patient's *insight*, not to have the patient adopt the therapist's *outlook*.

(e) At one point the therapist suggested that I talk with her about my concerns about her in the session rather than write letters commenting on her. If I offer my observations orally at the session, wouldn't those opinions also be projections? Is she saying I am permitted to project on to her orally in a session, but she wants me to refrain from projecting on to her in my letters? The fact is my previous therapist offered the same suggestion. When I later discussed my opinions about that therapist in the session – as she herself had previously recommended! – she became notably irritated. Her response to my oral comments about her were, "What does any of that have to do with you?"

(f) Erich Fromm said that creativity requires the courage to let go of certainties. One aspect of creative thinking is the ability to live and work with uncertainty, the ability to live and work with *not knowing*. Creative persons are able to house uncertainty in their minds and resist premature closure; they live in a world of possibilities. Less creative people need

certainty to a degree that is foreign to creative thinkers and will tend to reject ideas about which they don't feel certain, that is, they will tend to succumb to the temptation of premature closure. I have talked to the therapist about the fact that I hold many of my notions about the world as "tentative ideas," that is, ideas about which I am not certain, but which may or may not be true. My thoughts about "tentative ideas" seemed foreign to her. Is the therapist an individual who has a need for certainty? Does the therapist's apparent irritation with the ideas I express about her in my letters, in fact, result from her own projection of her *need for certainty* on to me? Does her projection of a need for certainty on to me lead her to believe that I state my ideas *with certainty* as facts, rather than as tentatively conceived notions about my world. In effect, does the therapist think: "He must be as certain of his ideas as I am of mine?" The problem is that I am certain of very little. I am struck by the therapist's repetition of the phase, "You need to take risks with people." In her mind, *I need to do that*. How does she know that? Can she prove that? She seems to be certain about her ideas in a way that I am not sure of my own. She seems to live in a world of "musts." *You need to think this. You need to do this.* Cult leaders talk like this. "I offer the road to salvation. If you accept me and my ideas, you will be saved." Dr. Charles Strozier, a psychoanalyst and professor of history at The City University of New York, has been studying and teaching classes on new religious movements for over two decades. "People who are vulnerable and needy and confused and often very troubled [like many therapy patients] . . . are drawn to the cult leader because *the leader offers certainty about what life is all about*, and what it should be all about," according to Dr. Strozier. "And that gives a wholeness and a completeness to their lives."

(g) At one point in the session I said that some of my previous therapists were "nasty" toward me. She immediately opined, with no evidence, "Maybe they acted that way because of your letters, I don't know." Why is that statement not a projection by the therapist onto my previous therapists? She seems to be saying, "I have negative feelings about your letters. It is probably also the case that your previous therapists had the

same reaction I have. (*That's the projection! Is she not saying, "I am rational and all your previous therapists were rational; I and your previous therapists have access to the same rationality, the same Truth."*) All therapists will react negatively to written criticism? That's factually untrue. Dr. Abas Jama, my psychiatrist in 2009-2010, said about one of my highly critical letters concerning him: "I read your letter. It was well written. You put a lot of thought into it. It showed very good thinking." Dr. Jama was a mature and secure medical doctor; he was not going to be flustered by something a mental patient wrote about him.

There is another implication to the therapist's statement, "Maybe they acted that way because of your letters, I don't know." The statement suggests that the therapist believes that if other people react negatively to me it is a rational and objective response to my "bad acts" – and not because of a subjective bias or irrational animus (counter-transference) by that therapist. She seems to say that authority figures will only react to me negatively because I provoke them. That raises questions about the sincerity of a solicitous statement this therapist made at the very first session after I told her that my father used to beat me when I was a boy: "He shouldn't have done that. You were just a child. Children misbehave. You did nothing wrong." Why wasn't the therapist thinking at this session, "Your past therapists were acting irrationally. They should not have reacted to you negatively. You were just a vulnerable therapy patient who was using writing as a form of self-soothing. Additionally, people with psychological problems sometimes act out. You did nothing wrong, as Jama recognized." It's as if at this session I was no longer the "good object" (an innocent child) as I was at the first session. Rather, the therapist transformed me into a "bad object" whose legitimate use of writing as a self-soothing measure aroused a paranoid response from the therapist, who was now the victimized "good object." Isn't that counter-transference? *Does the therapist hold simultaneously two opinions about me – as vulnerable child and victimizing adult – which cancel each other out, knowing them to be contradictory and believing both?*

The possibility that my letters and the therapist's reaction to my letters constitute a transference-countertransference enactment should be considered. Perhaps I have assigned (justifiably or irrationally) to the therapist the role of Big Brother, the fictional benevolent figurehead in Orwell's novel, 1984, whose beaming visage is a front for a totalitarian police state.

The psychoanalyst Leonard Shengold has written about Orwell that the writer's complex personality contained elements of both the authoritarian despot (Big Brother) and the fighter for justice and truth (the character Winston Smith). "George Orwell, the author bent on evolving a simple and honest prose, the fighter for truth and justice, or, more important, against lies and oppression. (We can speculate that his complex personality contained Big Brother and O'Brien as well as Winston Smith.) Chekhov wrote of having had to 'squeeze the serf out of [himself], drop by drop', and George Orwell must have made a similar effort; both men come through in their writing as truly moral and virtuous." Orwell, according to Shengold, exhibited massive splitting and isolative defenses (a vertical split): a split between the observing ego and experiencing ego. "The strength and pervasiveness of his isolative defenses do resemble what is found in those who have to ward off the overstimulation and rage that are the results of child abuse." In Shengold's opinion, Big Brother represents Orwell's own strong sadistic trend, which he constantly fought against. "I feel that he used his strong will and persistent determination to force himself away from some hated and feared part of his nature – probably these were primarily his sadistic and dominating impulses." Does my personality contain an *inner despot* against whom I fight with strong will and persistent determination?

(h.) Woody Allen once said: "All people know the same truth. Our lives consist of how we choose to distort it." May we paraphrase and say that it is our distortions of reality that make us individuals. Without our individual subjective reality, there would be only one rationality, one "absolute Truth" (as in a totalitarian state or a cult), we would all be the same – like undifferentiated infants in a maternity ward. We would have

no individual identity. We would be reduced to the status of prisoners, dressed in identical garb and assigned numbers. Is an appreciation of individuals' subjective reality associated with an anti-authoritarian ideal and a respect for freedom of expression (such as writing)? One wonders. One way a totalitarian regime seeks to stay in power is by denying human beings their individuality, eradicating independent thought through the use of propaganda and terror. Throughout 1984, the character Winston Smith tries to assert his individual nature against the collective identity the Party wishes him to adopt. He keeps a private diary (*compare my letters!*) and insists that his version of reality is the truth, as opposed to what the Party says it is. Does the therapist's semi-directive style ("You need to take risks with people," "It doesn't matter what my technical orientation is so much as you forming a relationship with me and developing the ability to accept what I say") promote my perception of her as a persecuting individual who is attempting to eradicate my individual identity?

(i.) Random psychoanalytic speculation:

There seems to be a subtext to the therapist's statements and views. Perhaps, the following:

People must only have rational and objective views. Subjective bias has no value; it is irrational and has no value in psychotherapy. Transference (the patient's projection onto the therapist) is wrong because it is not rational and objective; transference does not reflect Truth. There is no such thing as counter-transference. Therapists are always rational and objective; therapists have access to the same rationality, the same Truth. Psychoanalysis is bad (in a moral sense) because it shows no compassion for vulnerable people (as the therapist has said in the past). Perhaps psychoanalysis is also bad because it emphasizes fantasy and an analysis of the irrational – that is, psychic material that is not rational and objective.

I wonder about the following possible underlying unconscious schema in the therapist:

In the therapist's mind, perhaps factually right statements and beliefs –

are also "morally right or good." A factually wrong observation or belief is "morally wrong or bad." Is it possible that in the therapist's unconscious, the dichotomy of Right and Wrong *in a factual sense* is fused with Right and Wrong in a moral sense? To be right factually is to be good and right morally. To be wrong factually is to be bad and wrong morally. Transference is morally wrong because it is factually wrong (it is bad); it does not reflect Truth. Subjective bias is morally wrong because it is factually wrong. Perhaps, "Your letters are biased, they are projections, they are transference; that is, they are factually wrong. Your letters, since they are factually wrong, must also be morally wrong. Your letters are morally wrong and sinful and bad." Psychoanalysis emphasizes the analysis of irrational transference (the patient's projections) and intrapsychic fantasy. These ideas are factually wrong (they are irrational); therefore, psychoanalysis is morally wrong, bad and sinful.

If the therapist is saying, "I am only concerned with factual correctness and truth" is she not also saying, like a cult leader, perhaps, "I am morally right and holy."

Does this possible inference about the therapist relate to matters of narcissistic dynamics ("I am morally right and holy") as well as superego issues in her that complement the seeming expression of moral narcissism in me: I seem to have assigned myself the role of the dissident writer, Goldstein (or the free-thinking Winston Smith) who exposes the corruption of Big Brother, overseer of The Ministry of Truth, in Orwell's dystopian novel, 1984. That would be a transference-countertransference enactment. We see that perhaps I, like George Orwell, fight strenuously against my sadistic and dominating impulses with my strong will and persistent determination. One wonders how the therapist defends against her own sadistic trend and dominating impulses or whether she even recognizes these traits in herself? At my first session I said to the therapist, "I am ruthless." Does the therapist acknowledge this element in herself?

In the foregoing letter (Session: June 19, 2018) I discussed my ambivalent feelings about my therapist. The following dream write-up may offer insight into my ambivalent feelings in social relationships.

On February 6, 2014 I told my then treating psychiatrist (Mohammed Shreiba, M.D.) about a dream I had had the previous night.

The Dream of the Blackjack Tournament

I was having lunch with my friend Craig at a food court. In fact, from time to time Craig and I used to eat lunch at The Shops at National Place in downtown Washington. I had the sensation that this would be our last lunch together, the last time I would see him. In the dream I was 30 years old. I told Craig that I had enlisted in the U.S. Air Force. I had the feeling that telling Craig that I had enlisted in the Air Force would make him envious of me, which I relished. Craig told me that he was going off to play in a blackjack tournament.

Random Thoughts:

The previous day I had been reading a book titled *The Eichmann Trial* by the historian, Deborah E. Lipstadt. The book concerned the capture by Israeli agents of the Nazi war criminal Adolf Eichmann in Argentina in 1961 and his subsequent trial in Israel.

Craig's wife, Alexandra Zapruder used to work at the Holocaust Museum. She wrote a book called *Salvaged Pages: Young Writers' Diaries of the Holocaust*.

The previous week I had given a copy of a technical paper to my psychiatrist titled "Survivor Guilt and the Pathogenesis of Anorexia

Nervosa.” The paper’s author proposes that unconscious survivor guilt, a phenomenon first observed in Holocaust survivors, is a factor in the etiology of anorexia nervosa.

My psychiatrist pointed out the orality of the dream, the fact that I was having lunch with a friend. I had no thoughts about that issue.

I mentioned that Craig’s grandfather had been a pilot in the German air force and that Craig himself had tried to enlist in the U.S. Air Force. He was rejected because his eyesight was not up to standards. I explained to my psychiatrist that it gave me pleasure in the dream to taunt Craig with the idea that I was accepted by the Air Force knowing that his own wish to enlist had been thwarted. It was an instance of *Schadenfreude*, if you will.

I pointed out to my psychiatrist that airplanes have a phallic quality. The airplane in flight calls to mind the erect penis, defying gravity. I later thought of the fact that Craig was a womanizer: handsome, intelligent, and manipulative. The interpretation occurred to me that I was envious of Craig’s feats with women and wanted to make him envious of me in a matter (becoming a pilot) that had eluded him. (*The Eichmann Trial* includes a detailed discussion of Eichmann’s airplane flight from Argentina to Israel as a captured fugitive.)

My psychiatrist talked about the psychoanalytic theorist, Jacques Lacan. He said that Lacan emphasized the importance of looking at the precise words a patient uses. My psychiatrist said perhaps we should look, for example, at the phrase “Air Force”; perhaps we should isolate the word “Force” and think about the possible double meanings of that word. I experienced in that moment a shock of recognition. I immediately thought of the anality associated with the word *force* – the word’s relation to control, shame, and domination.

I mentioned to my psychiatrist that the author of *The Eichmann Trial* related the following anecdote: Upon Eichmann's capture in Buenos Aires he was taken by Israeli agents to a safe house for interrogation. During the interrogation, Eichmann asked to be allowed to go to the bathroom. From the bathroom Eichmann called out to the Israeli agents: "Darf ich anfangen?" – "May I begin." I reported that the Israeli agents were stupefied: "How could someone so submissive have been the architect of the Holocaust?"

The painful sense of loss associated with losing Craig as a friend in the dream ("I had the sensation that this would be our last lunch together, the last time I would see him.") may have disguised the narcissistic injury/loss associated with a bowel movement. Perhaps I thought unconsciously in devaluation, "He's just a piece of shit. Flush and move on." This points to the narcissistic aspect of my friendship with Craig – my investment in him was narcissistic in that he served as an object of twinship, idealization and mirroring; in other words, the relationship was not anaclitic. The loss of the stool is a narcissistic loss, a loss of a valued part of the self; its evacuation from the body arouses anxiety rooted in feelings of narcissistic loss; that which had previously been a valued part of the self is now devalued as worthless, something to be flushed down the toilet.

The word "anfangen" has importance to me as a devotee of the Wagner operas. There is a famous line in *Die Meistersinger von Nurnberg*, "Fanget An!" "Now Begin!" The novice Walther is directed by the Master, Beckmesser to begin his trial song, "to show his stuff" to the assembled masters who will evaluate his abilities.

Walther is introduced to the assembled mastersingers as a candidate for admission into the mastersinger guild. Questioned ("interrogated?") about his background, Walther presents his credentials. Reluctantly the masters agree to admit him, provided he can perform a master-song of his own composition. Walther chooses love as the topic for his song and is told that

he will be judged by the jealous Beckmesser alone, the “Marker” of the guild for worldly matters. At the signal to begin (*Fanget an!*), Walter – seated in a chair (think of a toilet) – launches into a novel free-form tune, breaking all the mastersingers’ rules, and his song is constantly interrupted by the scratch of Beckmesser’s chalk on his chalkboard, maliciously noting one violation after another. When Beckmesser has completely covered the slate with symbols of Walter’s errors, he interrupts the song and argues that there is no point in finishing it. Walter’s mentor, Hans Sachs tries to convince the masters to let Walter continue, but Beckmesser sarcastically tells Sachs to stop trying to set policy. Raising his voice over the masters’ argument, Walter finishes his song, but the masters reject him and he rushes out.

Once again the salient issues in the opera *Die Meistersinger* are, as in my dream, jealousy, an attempt to enlist, and rejection. Walther seeks to enlist in the mastersinger guild, but his ambitions are thwarted by Beckmesser’s jealous nit-picking. He is rejected.

Does my association to the war criminal Adolf Eichmann point to my own sadistic trend and dominating impulses? I am reminded of the testimony of the concentration camp survivor, Yehiel Dinur at the Eichmann trial. During his testimony, as he looked at Eichmann in the courtroom, Dinur fainted after several minutes of examination by the prosecutor. He was later asked why he fainted: Was Dinur overcome by hatred? Fear? Horrid memories? No; it was none of these. Rather, as Dinur explained, all at once he realized Eichmann was not the god-like army officer who had sent so many to their deaths. This Eichmann was an ordinary man. "I was afraid about myself," said Dinur. ". . . I saw that I am capable to do this. I am . . . exactly like he." May we say that Dinur recognized that his personality contained elements of Big Brother even as it contained elements of Winston Smith? I am reminded also of an observation of Erich Fromm's: "I heard a sentence from Dr. Buber recently about Adolf Eichmann, that he could not have any particular

sympathy with him although he was against the trial, because he found nothing of Eichmann in him. Now, that I find an impossible statement. I find the Eichmann in myself, I find everything in myself; I find also the saint in myself, if you please." Erich Fromm, *The Art of Listening*.

I later had thoughts about the sexual implications of Craig saying he was going off to play in a blackjack tournament. Freud said that gambling was symbolic of masturbation. In early March 1991, while I was working as a paralegal at the law firm Akin Gump Strauss Hauer & Feld, I telephoned Craig on a Saturday morning at his home. We chatted for a while. (I had the paranoid perception at the time that Craig tape-recorded the conversation, delivered the tape to Akin Gump (my employer), and that the tape was played for Bob Strauss, founder of the firm. There seemed to be a hubbub at the firm the following week; Bob Strauss saw me and he couldn't hold back a smile. Why, I thought at the time, would Bob Strauss smile at me in that way? Bob Strauss was a poker player, by the way.) I asked Craig during the telephone call, "What do you do? (That is, how do you spend your time?)" Craig said: "Nothing. I work and I masturbate. I work all day. I come home, and I masturbate." (Note the flippant arrogance so typical of phallic narcissists.)

I note that the word *flush* has a double meaning. It refers to the mechanics of a toilet as well as to the card game, poker. A *flush* is a poker hand containing five cards all of the same suit, not all of sequential rank, such as K♣ 10♣ 7♣ 6♣ 4♣ (a "king-high flush" or a "king-ten-high flush"). When we worked together I pointed out to Craig that his name Craig Dye is an anagram of the phrase "gray dice," which connotes gambling.

One of my previous dream interpretations refers to the issue of gambling and masturbation in connection with Craig.

I mentioned to my psychiatrist that the previous summer I had spent two weeks at a hotel casino in Atlantic City, The Tropicana Hotel (an allusion

to South America? Eichmann was captured in Argentina.) There was a food court at the Tropicana Hotel. One of my earlier dream interpretations took place at a hotel.

The psychiatrist, Dr. Shreiba, offered no interpretations.

A Kleinian Dream: The Dream of the Ardent Zionist

In May 1991 I had three consultations with Lawrence C. Sack, M.D., a psychiatrist/psychoanalyst (now deceased) whom I idealized. Dr. Sack had served as President of the Washington Psychiatric Society. He died in 2003, and I felt the loss deeply.

Upon retiring on the evening of Tuesday November 6, 2012 (a presidential election night) I had the following dream:

The Dream of the Ardent Zionist

I am alone with Dr. Sack. I tell him that I have a collection of eight books that form a series concerning the history of the Jewish people and Zionism. The books are old. I tell Dr. Sack that one of the books in the series has several papers promoting Zionism written by a "Lawrence C. Sack." I ask Dr. Sack if he is the author of the papers. He acknowledges that he is the same Lawrence C. Sack. He tells me that in his youth he was an ardent Zionist who lived in Israel and that he wrote numerous papers promoting the Zionist cause. I show Dr. Sack a photograph in the book depicting a young man dressed casually in short pants and a short-sleeved shirt. I think he looks like a Zionist pioneer, an agricultural worker, perhaps. Dr. Sack says that is in fact a photo of him that was taken in his youth while he lived in Israel. I think: "He looks so young, so unlike the man in his sixties standing before me." When I look closely at the face I see that the photo is indeed one of Dr. Sack. I think: "How strange! What an odyssey: from Zionist

pioneer living in Israel to a psychiatrist/psychoanalyst living in the United States.”

The thought occurs to me that the photograph of the young Dr. Sack in the manifest dream represents an image of my mother that I had internalized when I was a young boy, and when my mother, too, was young. I believe the dream work disguised what was in reality a mother transference into a father transference; that is, what appears to be a dream about a displaced image of my father (Dr. Sack) is, in reality, a displaced image of my mother. The manifest dream presented a deception, or misdirection: an act of dream censorship. But why would that be? The dream perhaps concealed my feeling that my real mother, as I came to know her in later childhood, was wholly inadequate. The manifest dream is noisy in its proclamation that it concerns my father: the male figure (Dr. Sack); Zionism (my father was Jewish, my mother Polish-Catholic); reading and books (my mother hated books; it was my father who was a reader). The theme of the agricultural worker might relate to my mother; my mother had a vegetable garden in the back yard of our house, which she doted on each summer. She grew tomatoes, cucumbers, green peppers and other vegetables. What painful feelings about my mother did the dream censor? What psychic turmoil did the dream conceal?

Reference to Melanie Klein’s writing about so-called unconscious depressive anxiety provides an orientation to understanding the possible meaning of the dream, that is, the unconscious anxieties about my mother that fueled the dream work, Freud’s term for the unconscious ciphering that transforms the dream’s latent content into the manifest content. Is it possible that the photographs of the young Dr. Sack referenced in the dream symbolize a beautiful picture of my mother that I early internalized, but one which I feel to be a picture of her only, not her real self? In adulthood, perhaps, I feel my mother to be unattractive—really an injured, incurable and therefore dreaded person.

In a paper titled “A Contribution to the Psychogenesis of Manic-Depressive States” (1935), Klein writes:

“I have tried to show that the difficulties which the ego experiences when it passes on to the incorporation of whole objects proceed from its as yet imperfect capacity for mastering, by means of its new defense-mechanisms, the fresh anxiety-contents arising out of this advance in its development. I am aware how difficult it is to draw a sharp line between the anxiety-contents and feelings of the paranoiac and those of the depressive, since they are so closely linked up with each other. But they can be distinguished one from the other if, as a criterion of differentiation, one considers whether the persecution-anxiety is mainly related to the preservation of the ego—in which case it is paranoiac—or to the preservation of the good internalized objects with whom the ego is identified as a whole. In the latter case—which is the case of the depressive—the anxiety and feelings of suffering are of a much more complex nature. The anxiety lest the good objects and with them the ego should be destroyed, or that they are in a state of disintegration, is interwoven with continuous and desperate efforts to save the good objects both internalized and external.

It seems to me that only when the [infant’s] ego has introjected the object as a whole and has established a better relationship to the external world and to real people is it able fully to realize the disaster created through its sadism and especially through its cannibalism, and to feel distressed about it. This distress is related not only to the past but to the present as well, since at this early stage of development the sadism is in full swing. It needs a fuller identification with the loved object, and a fuller recognition of its value, for the ego to become aware of the state of disintegration to which it has reduced and is continuing to reduce its loved object.

The ego finds itself confronted with the psychical fact that its loved objects are in a state of dissolution—in bits—and the despair, remorse and anxiety deriving from this recognition are at the bottom of numerous anxiety-situations. To quote only a few of them: There is anxiety how to

put the bits together in the right way and at the right time; how to pick out the good bits and do away with the bad ones; how to bring the object to life when it has been put together; and there is the anxiety of being interfered with in this task by bad objects and by one's own hatred, etc. Anxiety-situations of this kind I have found to be at the bottom not only of depression, but of all inhibitions of work. The attempts to save the loved object, to repair and restore it, attempts which in the state of depression are coupled with despair, since the ego doubts its capacity to achieve this restoration, are determining factors for all sublimations and the whole of the ego-development. In this connection I shall only mention the specific importance for sublimation of the bits to which the loved object has been reduced and the effort to put them together. It is a 'perfect' object which is in pieces; thus the effort to undo the state of disintegration to which it has been reduced presupposes the necessity to make it beautiful and 'perfect'. The idea of perfection is, moreover, so compelling because it disproves the idea of disintegration."

And here is the crucial portion of the Klein's text.

"In some patients who had turned away from their mother in dislike or hate, or used other mechanisms to get away from her, I have found that there existed in their minds nevertheless a beautiful picture of the mother, but one which was felt to be a picture of her only, not her real self. The real object was felt to be unattractive—really an injured, incurable and therefore dreaded person. The beautiful picture had been dislocated from the real object but had never been given up, and played a great part in the specific ways of their sublimation."

Note about the Jews, Zionism and Depressive Anxiety

I did not grow up in a Jewish home or have a Jewish education. My father had an Orthodox Jewish background, while my mother was Polish-Catholic. My parents had chauvinistic attitudes toward their respective

cultures, and religion was a common source of my parents' discord. My mother's family — her mother and older sister — were either overtly or covertly antagonistic toward my father; I suspect their attitudes toward my father were antisemitic in origin. From early childhood I identified as a Jew and, beginning in my teens, became preoccupied and fascinated with *all things Jewish*. I have a near obsession with the struggles of the Jewish people, their survival, antisemitism, and the precariousness of the State of Israel.

Might we see my Jewish concerns as rooted in Kleinian depressive anxiety? Perhaps, for me, the Jews represent the internalized good object with which my ego is identified as a whole. My anxiety lest the good object, with which my ego is identified, should be destroyed, or that it is in a state of disintegration, is interwoven with continuous and desperate concern for its welfare and survival. I fear for the good object and the disaster created through my own sadism and especially through its cannibalism, which is externalized in anxieties about antisemitism and Jewish survival. With my identification with the Jews came a fuller sense that their survival was linked to the survival of the good within me, and I developed a fuller recognition of the value of Jewish culture, which made me all the more aware of the state of disintegration to which the Jewish people are threatened.

Thinking about the founding of the State of Israel in 1948 following the Holocaust I am reminded of Hanna Segal's exquisite quote: "It is when the world within us is destroyed, when it is dead and loveless, when our loved ones are in fragments, and we ourselves in helpless despair — it is then that we must recreate our world anew, reassemble the pieces, infuse life into dead fragments, recreate life." An insistent concern for the survival of the goodness in the world haunts my thinking in so many facets of my mental life, a concern that seems grounded in my sense that my own internal goodness is in perpetual peril from my sadism.

These ideas seem related to Leonard Shengold's observation about George Orwell: "I feel that he used his strong will and persistent determination to force himself away from some hated and feared part of his nature - probably these were primarily his sadistic and dominating impulses."

Therapy Session: July 17, 2018

At the previous session, on July 10, 2018, the therapist talked about my need to develop a relationship with her. She talked about my need to develop trust in her and others. She asked me to define the word trust. She talked about change, that is, therapeutic change in treatment. She talked about her view that she offered an emotionally-corrective relationship with me. I experienced her observations as coercive and as of questionable value. I see the change and trust growing out of the therapy process as fundamentally nonvolitional reactions by the patient. Many therapists, including Christopher Bollas, argue that psychotherapy is primarily efficacious due to entirely unconscious processes of change. This therapist seems to view trust and change as volitional acts over which the patient has control. At the conclusion of the session I had given the therapist a legal document: an affidavit I planned to send to the FBI detailing my belief that my Social Security Disability claim was fraudulent and that my last employer's written statements about its termination decision, alleging that I was unemployable, were perjured.

[The therapist ignores the extent to which her own statements and behaviors affect a patient's ability to trust her. At the first consult, I spoke with the therapist about an earlier consult I had had with another one of the clinic's therapists. I reported to the therapist statements that the previous therapist had made to me on that earlier occasion. The therapist replied, "I can't comment on what you discussed with him; I wasn't there." More recently, I reported on a conversation I had had with the Director of my mental health clinic. I reported statements that the Director made to me. The therapist, without hesitation, offered her own interpretation of the meaning of the Director's statements. (*I thought the therapist could not comment on conversations to which she was not privy.*) The therapist's own behavior and statements at times offer unintentional clues

into her motives and unstated psychological agendas. In this instance, the therapist showed that at times she relies on rationalization to justify what is convenient for her to say at any particular moment. Such behaviors impair a patient's ability to trust a therapist. It is also well to keep in mind that trust is intimately connected to a person's cognitive abilities. A patient with unusual memory, perceptiveness and intuition may react to a therapist in a different way than a patient with average memory, perceptiveness and intuition.]

THE SESSION:

PATIENT: So I didn't write a letter this week. Actually, I was thinking about writing a letter, but I didn't. I mean, you said things last time that troubled me, but I ended up not writing a letter. I thought I would just talk today about what troubled me about our last session.

[The therapist herself had previously suggested to me at an earlier session that instead of writing a letter about my thoughts triggered by the sessions, I should just talk directly with the therapist about what troubled me. In effect, the therapist herself had invited me to talk about my concerns about our work. By talking directly with the therapist about my concerns, I was doing what I had previously been told to do by the therapist herself. Keep this fact in mind.]

So, first of all, there's something that's been on my mind for some time. Something that happened at the first session. You asked me at that time what I felt when I interacted with people. I said that I had strong feelings of alienation. And you said, "Many of the people I work with talk about loneliness and a fear of rejection." Based on things I've read, what you said doesn't make sense to me. I was reading that there are in fact three different adult avoidant attachment styles. There's fearful avoidance, that

is, the classically shy person. A person like that wants relationships but is fearful of interacting with people. A person like that will talk about loneliness and fear of rejection. They get lonely because they actually want friends, but they are afraid to interact with people. Then there's something called "preoccupied attachment." That's a person who is preoccupied with relationships. These people want friends and need to be liked and they're always worried about being liked and accepted by others. It's a type of attachment insecurity, though these people have friends—they are just anxious about the relationships they have. But then there's a third type: dismissive avoidant attachment. Dismissive people dismiss the value of relationships altogether. They pride themselves on independence and pathological self-sufficiency. I'm like that. I don't experience loneliness, generally. And I seem to pride myself on being independent of others. So what I'm thinking is that what you said at our first session just doesn't make any sense, really. Dismissive avoidant people will not complain about loneliness. I'm not even aware of being lonely. That's something that a fearful avoidant person would say or a person with preoccupied attachment would say, but a dismissive person wouldn't even talk about that. What you said just doesn't make sense to me. And this is what really bothers me. It's as if you need to see me as a fearful avoidant person. It's like you need to push me into that category. I have the feeling you try to force feelings on me that I don't even have. You don't seem to know about the basic attachment styles.

And then I've talked about what's called an introjective personality. I'm obsessed with my identity – who I am – and defining myself. That's what an introjective person is. I read last week that the introjective personality is the equivalent of the dismissive avoidant person in attachment theory. So that's additional evidence that I have a dismissive avoidant attachment style and not a fearful avoidant attachment style. You know, I read that they say that psychoanalysis or psycho-dynamic therapy is the treatment of choice with introjective patients.

You know, I feel like I'm a dolphin and you think I'm a fish. Let's say you don't even know what a dolphin is. And the only category you can put me in is fish. So I am a fish to you. Then I do things like surface for air and you think, "Why does he do that? Fish don't surface for air." Well, I'm not a fish! That's why. You create a disturbing situation for me by forcing me to be somebody I am not.

It's like that old expression. The square peg and the round hole. It's like I'm a round hole and you're trying to force a square peg into me. It's disturbing to me.

[Note the oral implications of my observation: "*It's like I'm a round hole and you're trying to force a square peg into me.*" The statement seems suggestive of the mother forcing her nipple into the infant's mouth and forcing the infant to be a container for her milk. The symbolism is suggestive of schizoid pathology. One psychoanalyst has written: "I have heard a number of schizoid individuals describe their mothers as both cold and intrusive. For the mother, the coldness may be experienced as coming from the baby. Several self-diagnosed schizoid people have told me their mothers said that they rejected the breast as newborns or complained that when they were held and cuddled, they pulled away as if overstimulated. A friend confided to me that his internal metaphor for nursing is "colonization," a term that conjures up the exploitation of the innocent by the intrusive imperial power. Related to this image is the pervasive concern with poisoning, bad milk, and toxic nourishment that commonly characterizes schizoid individuals. One of my more schizoid friends once asked me as we were having lunch in a diner, "What is it about straws? Why do people like to drink through straws?" "You get to suck," I suggested. "Yucch!" she shuddered." McWilliams, N. "Some Thoughts about Schizoid Dynamics."

In a broader sense, my statement, "*It's like I'm a round hole and you're trying*

to force a square peg into me" is suggestive of a concern centering on fears of maternal engulfment – a concern that is intimately connected to my perceived need for an idealized male as a defense against my fear of being devoured by a woman. I had earlier offered the observation, based on the work of Kohut and Blos, that my object hunger, my idealizing merger needs are fixations on archaic pre-oedipal forms deriving from deficits emerging out of my relationship with an engulfing mother who used me for her own selfobject needs and in my frustrating relationship with a father unavailable for idealization. Cowan, J. "Blutbruderschaft and Self Psychology in D.H. Lawrence's *Women in Love* in Self and Sexuality." My idealization of males is a defense against being swallowed up by a woman. See Shengold, L. *Soul Murder: The Effects of Childhood Deprivation and Abuse*. My psychology parallels Kohut's patient Mr. U, who, turning away from the unreliable empathy of his mother, tried to gain confirmation of his self through an idealizing relationship with his father. The patient's mother had exposed him to intolerably intense and sudden swings in his nuclear self-esteem. On innumerable occasions she appeared to have been totally absorbed in the child – overcaresing him, completely in tune with every nuance of his needs and wishes – only to withdraw from him suddenly, either by turning her attention totally to other interests or by grossly and grotesquely misunderstanding his needs and wishes. Already in early childhood the patient had tried to secure his narcissistic balance by turning from the attempt to obtain confirmation of his self with the aid of his mother's unreliable empathy to the attempt to merge with his idealized father. But Mr. U's father could not respond appropriately to his son's needs. He was a self-absorbed, vain man, and he rebuffed his son's attempt to be close to him, depriving him of the needed merger with the idealized selfobject and, hence, of the opportunity for gradually recognizing the selfobject's shortcomings. Kohut, H., *The Restoration of the Self*.

To some extent we may view my fear of maternal engulfment and my corresponding need for an idealized male as a defense against that fear as

a universal struggle; perhaps, the struggle is only particularly intense in me. Blos has written: "The role of the early father was that of a rescuer or savior at the time when the small child normally makes his determined effort to gain independence from the first and exclusive caretaking person, usually the mother. At this juncture the father attachment offers an indispensable and irreplaceable help to the infant's effort to resist the regressive pull to total maternal dependency, thus enabling the child to give free rein to the innate strivings of physiological and psychological progression, i.e., maturation." Blos, P. "Freud and the Father Complex." Applying Blos, we may perhaps say that my failure to resolve the dyadic father idealization that emerged at the earliest stages of development has had significant, even profound, reverberations in my adult life. My dyadic father attachment was never subjected to a sufficient or lasting resolution during my adolescence, namely, at that period in life when the final step in the resolution of the male father complex is normally transacted. Blos, P. "Freud and the Father Complex."

My focus in this session on a fear of maternal engulfment as encapsulated in the phrase, "*It's like I'm a round hole and you're trying to force a square peg into me*" suggests that a latent concern in this session may be a need for a defense against that fear. At least that proposition seems consistent with the insights of Blos and Kohut. Perhaps my expressions about a fear of maternal engulfment always contain the following latent concern, namely, my unexpressed "*need to seek an idealized friend who exists only as a projection of my own needs – an ideal friend who would be an extension of myself*" – an idealized friend who would save me from the peril of being devoured by my mother.]

PATIENT [continuing]: It's funny, earlier today, I was reading a book by a psychiatrist. It was a whole book about dismissive avoidant people. People like me. And he says that traditionally, therapists don't take dismissives seriously. They tend to think of isolated people as struggling with shyness. He says most therapists see dismissives as the "walking well."

Oh, and another thing. About forming a relationship with you. I don't feel I have a relationship with you, not the kind that you want. You seem to think that's something I could do, but out of willfulness I don't form a relationship with you. You look at your other clients and see them form a relationship with you, and you probably think it's something that they are doing. That they have made a conscious decision to trust you and form a relationship with you. But these are really automatic responses. Whether a person forms a relationship or doesn't form a relationship is an automatic response, to a large degree. People don't consciously make a decision to trust somebody. Trust emerges out of the relationship. A relationship is an automatic response. You either form a relationship with somebody or you don't. When a patient forms a relationship with you it's not a conscious act of cooperation. It's not like he's thinking, "I want to get better. So I will need to form a relationship with this therapist. I will make a conscious effort to form a relationship with this therapist." That's not what happens for the most part. It's an automatic response by a person. In the same way, my not forming a relationship with you is an automatic response. Or, let's say, the absence of an automatic response. So a good way to think of it is that people will either have an automatic response or a person will have the absence of an automatic response. But the absence of an automatic response is not a conscious, willful act of defiance by the patient. It's simply the absence of an automatic response. They simply have a personality style in which they have an automatic response. I have no control over that. With me – it's not that I am uncooperative or thwarting you, it's not volitional or conscious, it's simply the absence of an "automatic response." You seem to think if I don't have a relationship with you I am doing that. I'm not doing anything. It's not a matter of doing anything. Trust is something that emerges. It's based on feelings that emerge or don't emerge. It's like what happens in groups. People bond in groups as an automatic response. Group theorists say it's defensive to some extent. I don't bond in groups. To some extent my not bonding in groups is the absence of a defensive reaction to other people. People bonding in groups is not a volitional act at a psychological level –

if you put people together they bond in a group automatically out of psychological needs. The failure to bond in a group is a result of psychological processes that are not volitional.

[“Small, closed, and unstructured groups—as well as groups that are large, minimally structured, and lacking clearly defined tasks to relate them to their environment—tend to bring about an immediate regression in the individual, a regression that consists in the activation of defensive operations and interpersonal processes that reflect primitive object relations.” Kernberg, O.F. *Ideology, Conflict and Leadership in Groups and Organizations*. This is precisely what *does not* happen to me in groups. In group situations I tend to retain my thinking, my individuality and my rationality; and because of that I tend to be attacked in groups.
“Gradually, it becomes evident that those who try to maintain a semblance of individuality in this atmosphere are the ones who are most frequently attacked.” Kernberg, *Id.*]

You impute control to me all the time in ways I don’t have control. I have control over my behavior, but I don’t have control over my feelings. Writing letters is a behavior. I can control that. I can make a conscious decision to stop writing letters. But I have no control over the underlying feelings — feelings of confusion, the sense that you say things that don’t make sense to me, the feeling of being overwhelmed [or engulfed] by you. I will continue to have those feelings whether or not I write letters. There are so many things I don’t have control over. I have no control over dissociation. A person can’t make a decision not to dissociate. I have no control over my lack of social interest. I can’t feel an interest for people I don’t have. I have no control over my feelings of alienation; my feeling that I am very different from other people. I can’t decide I won’t feel alien anymore. I have no control over whether I idealize somebody or not. I can’t make a conscious decision not to idealize somebody. I have no control over my tendency to retreat into fantasy. I have no control over

my self-criticism. I have no control over any of these things. You burden me with this idea that there are things that I can do to change these feelings. It's not a matter of doing anything.

Oh, I want to mention something I never mentioned before. I think this is important. It's an anecdote about my mother. You know, when my mother died I wasn't very emotionally affected by that. I think that's significant. I was in my first year of law school at the time. It was in January 1980. I was living in Spokane, Washington at the time, 3,000 miles from home. I was all alone. I had no friends. I mean, that's typical, I don't have friends. I had no family. I had no social support of any kind. And I had the pressures of law school to deal with. I studied and studied and I completed my first year of law school at the top 15% of my class. So that's psychologically interesting. Because I read that many dismissives – and they pride themselves on independence and self-sufficiency— but what I read is that many dismissives will break down in the case of a severe emotional crisis, even though they tend to be independent of others. But, I'm not like that. When my mother died, I didn't break down, "I just soldiered on."

[I am reminded of the analyst Leonard Shengold's observation about one of his patients: "He spoke of life in military metaphor, as a war with battles, retreats, campaigns." *Soul Murder: The Effects of Childhood Abuse and Deprivation.*]

I don't mean to denigrate you but you are obsessed with relationships. I am not interested in a relationship with you (in the sense of an emotionally-corrective experience). The important thing to look at, as far as I can see, is how I perceive you. That has psychological meaning. Not an actual relationship. What we need to look at is what role I have assigned you. That's what's important, not the emotionally corrective experience.

Dr. Palombo never talked about relationships. I wanted to talk about relationships with him. But he didn't seem interested. I was friendly with Craig at that time. And I asked Dr. Palombo why Craig didn't seem interested in being friends with me and Dr. Palombo's only comment was, "Craig has his own agenda, I don't know what that is." Dr. Palombo [a psychoanalyst] was concerned with my inner world. What was going on with me psychologically – not with relationships. Years ago, I said to a psychiatrist, "I'm not sure I want to have friends." And he said, "You don't have to have friends if you don't want to."

THERAPIST: How do you feel about being seen as different from other people?

[At an earlier session, I had told the therapist that I felt alien around people; that I felt a sense of alienation around people. The therapist replied: "*Let me show you how that is really a fear of rejection.*" She seemed to suggest that I associated the state of "alienness" with shame. She explained that perhaps I worry that if I feel different from others, I will fear being rejected by them, instead of assuming that if I feel alien I will fear that I will be prevented from experiencing narcissistic mirroring. That is, the therapist associates being different with an impaired ability to form relationships rather than a fear that a needed source of narcissistic supply will be thwarted. An individual who has an intense need to idealize others (a property that might be associated with a *fear of engulfment*) will fear the lack persons available for mirroring.

In asking the question, "*How do you feel about being seen as different from other people?*" perhaps the therapist was trying to solicit comments about my fearing rejection by others because of my "differentness." On an earlier occasion, when I reported a coworker's statement, "*We're all afraid of you. We're all afraid you're going to buy a gun, bring it in and shoot*

everybody!" – the therapist asked, "Did that make you feel bad?" When I told the therapist about my letters to the FBI, she replied: "Aren't you concerned about how your letters are received by the FBI?" The therapist seems to project onto me concerns about the negative evaluations of others, as if she herself is preoccupied with how I perceive her and whether I value her. In fact, dismissive avoidant persons are notably unconcerned with the opinions or negative evaluations of others – another possible instance of the therapist imputing to me characteristics of a preoccupied or fearful avoidant attachment style.

Permit me a digression at this point. People differ in how they react to social rejection. Persons with an interdependent self (and that would include persons with a fearful avoidant attachment style and a preoccupied attachment style) will experience social rejection as aversive and will tend to engage in reparative strategies with others to forestall further rejection. Persons with an independent self-construct (those with a dismissive attachment style?) or creative persons will not experience social rejection as aversive. For some dismissives social rejection will enhance their drive to differentiate themselves further from others. Let me quote from Sharon Kim's paper, "Outside Advantage: Can Social Rejection Fuel Creative Thought?" which provides important insights about how creative dismissives react to social rejection.

"In his seminal book, *The Outsider*, Colin Wilson (1956) argued that eminently creative people live on the margins of society, rejected for playing by their own rules in an environment that demands conformity. Of course, the very traits that distinguish highly creative people, such as unconventionality, make them easy targets for rejection. The implications of Wilson's provocative thesis – Is there a causal link between social rejection and creativity? – merits investigation. Considerable research seems to suggest otherwise given the numerous deleterious effects of rejection on cognitive performance, especially on tasks that require executive control. It is theorized that rejection influences cognitive processes because the experience thwarts a core need to belong. Self-regulation, an effortful

process, becomes less of a priority when social acceptance appears to be out of reach, resulting in decrements in cognitive performance.

One study has found that the negative consequences of social rejection are not inevitable and may depend on the degree of independence in one's self-concept. The self-concept may shape responses to rejection because independent selves are motivated to remain distinctly separate from others. This motivation is pivotal because, for these individuals, the experience of rejection may trigger a psychological process that stimulates, rather than stifles, performance on creative tasks.

While it is true that people have a strong motivation to form and maintain relationships, the need to belong is not the only social motive nor is it always most salient. Indeed, the need to individuate has been shown to be an equal, if not stronger, motive in certain situations. For instance, individuals with an independent self-concept tend to think of themselves as separate from others and to emphasize personal goals over group goals. An independent self-concept has been shown to blunt some consequences of rejection including embarrassment. These people remain less sensitive to rejection because of the reduced value placed on being part of a group. For independent selves, individuality is a positive distinction; and therefore, rejection may strengthen this sense of independence. In contrast, the motivation to fit in and maintain harmony with the group will likely drive interdependent selves to respond to rejection by engaging in reparative strategies like strengthening friendships and even mimicry to signal the desire to affiliate.

The willingness to distinguish one's self from others has important implications for performance on creative tasks. Creativity is a process by which ideas are recombined to yield solutions that are both novel and appropriate. Exploring remote or unusual ideas can increase the probability of reaching creative solutions. Given that creative solutions are by definition unusual, infrequent, and potentially controversial, they are stimulated by the desire to stand out and to assert one's uniqueness. In other words, the need to be seen as separate from others within groups promotes nonconformity and can lead to more creative outcomes.

It has been posited that for individuals with an independent self-concept, rejection may amplify feelings of distinctiveness and increase creativity by conferring the willingness to recruit ideas from unusual places and move beyond existing knowledge structures. In contrast, among individuals with an interdependent self-concept, the effort to conform and regain approval from others may preserve self-esteem, but may also extinguish the sense of independence that is optimal for producing creative solutions. Therefore, we hypothesize that for individuals with an independent self-concept, rejection will reinforce their desire to differentiate themselves from others and that mindset should, in turn, lead to more creative outcomes.”

I fear that the therapist, who has a non-dismissive attachment style, may not be able to enter the inner world of an individual with an independent self-concept. I fear that the therapist is an individual with an interdependent self-concept that will compel her to affiliate in order to gain the approval of others to preserve self-esteem. She seems unable to see individuality as a positive distinction; in her view, individuality thwarts the formation of relationships, thereby denying the individual what she sees as a needed source of self-esteem, namely, the state of belonging.

Perhaps, my lengthy opening comments — which seemed to repudiate the therapist and her work — had made the therapist herself feel that I was rejecting her, which threatened her self-esteem. In soliciting comment from me about feeling different from others — or fearing being “rejected” by others (as an alien) — she was seeking out an object of projection onto whom she could displace her own feelings about being rejected (alien) — feelings that I had triggered in her. Perhaps, the therapist was seeking out a container for her feelings of being rejected by me.

It would be useful to think about the following transference-countertransference enactment. *Patient arouses unconscious bad feelings in the therapist. The therapist then tries to abreact those bad feelings by having the*

patient talk about those very feelings. The therapist becomes enraged when the patient seems invulnerable to those feelings that the therapist is trying to project onto the patient. That is, the patient denies the therapist a container for the bad feelings that the patient triggers in the therapist.

Unfortunately for the therapist her question “*How do you feel about being seen as different from others?*” prompted me to recite anecdotes about feelings of *superiority and invulnerability* – not emotional *vulnerability*, as she may have wanted and expected. In reciting the following grandiose anecdotes, perhaps I denied the therapist an object of projection, which may have triggered her rage. I denied the therapist a *container* for her feelings of rejection that I had triggered.]

PATIENT [continues]: You know, I have mixed feelings about being seen as different from others. It depends. Like sometimes it's an ego boost. I like to be different from other people. I like to be unique. And some people see me as different, as unique. Like years ago, in law school, we had this wine and cheese get-together and I could hear another student talking off to the side, “You see that guy over there? That's Gary Freedman. When he talks in class, you could hear a pin drop. Everybody wants to know what he's going to say.” So he saw me as different, but in a good way. And then there was this other time in October 1987. I was working as a temporary employee at that time. And the temporary agency I worked for had a wine and cheese get-together for employees. I attended. There was a radio reporter there for Voice of America. He was doing a story on “Temping in America.” So he interviewed me and other people. After I was done talking, he said to me, “I've never talked to anybody like you before. This interview was terrific. I'm going to lead with this interview. This interview is going to make my story.” And he was a reporter. He interviews people all the time. So that was unusual. So, you know, it can be an ego boost when people think I am different and unique. But then my supervisor said I was a homicidal maniac. So she saw

me as different in a bad way. So that wasn't good.

[End of twenty minute soliloquy by patient.]

THERAPIST [apparently irritated]:

Why do you come to therapy? What are you trying to get out of therapy?

[I had the sense that the therapist was irritated, among other things, by my lack of emotional vulnerability and by my criticism of her (or *rejection* of her) during my lengthy opening comments. But that lack of emotional vulnerability is the *sine qua non* of dismissive avoidant attachment style or the introjective personality.]

PATIENT: I want somebody to talk to. I feel I need somebody to talk to. I like to talk. I like to talk about myself. And I don't have any friends. I don't have any social contacts. And, of course, with a friend there has to be give-and-take. You can't just talk about yourself. And another thing, in a social relationship, you can't talk about things that you can tell a therapist.

[Do these comments relate to my need for a defense against maternal engulfment that I had talked about earlier? Am I saying about myself, "I need to seek an idealized friend who exists only as a projection of my own needs – an ideal friend who would be an extension of myself" – an idealized friend who would save me from the peril of being devoured by my mother?

Importantly, my autobiographical book, *Significant Moments*, contains a passage about a person's need to pour out his thoughts and feelings to an *Idealized Other*.

Even as a boy of seventeen, he was looking for a companion ‘to whom I could pour out my inmost being to my heart’s content, without my caring what the effect might be on him.’

Anthony Storr, *Feet of Clay—Saints, Sinners, and Madmen: A Study of Gurus quoting Richard Wagner.*

Could it be in reality he had had no friend at all, possessed no share in someone else’s life? He had had a companion, a listener, a yes-man, a henchman, and no more!

Hermann Hesse, *Tales of Student Life.*

The intensity with which . . .

Phyllis Grosskurth, *The Secret Ring: Freud’s Inner Circle and the Politics of Psychoanalysis.*

. . . later in life . . .

Charles Darwin, *Origin of Species.*

. . . he entered into his largely epistolary friendship with Wilhelm Fliess must have been a reflection of his disappointment with reality and his need to seek an idealized friend who existed only as a projection of his own needs. For Freud the ideal friend had to be an extension of himself.

Phyllis Grosskurth, *The Secret Ring: Freud’s Inner Circle and the Politics of Psychoanalysis.*

Phyllis Grosskurth’s observations about Freud’s friendship with Wilhelm Fliess brings us back to Peter Blos’s paper “Freud and the Father Complex,” which proposes that the psychological underpinning of Freud’s idealized friendship with Fliess was Freud’s own fear of maternal engulfment. The therapist seemed oblivious to all of the important issues I raised in the session and instead turned to her own hurt feelings – an obvious countertransference response.]

THERAPIST [erupting in anger]: Why don’t you just talk to a wall? You

don't need a therapist. You might as well just talk to a wall! I need to give feedback!

[The therapist's statement "*I need to give feedback*" is interesting. I didn't prevent the therapist from giving feedback to anything. The therapist was free to interpret any of the issues that I raised in my opening comments. What about the issues relating to the recognized facets of dismissive avoidant attachment style? What about the possible schizoid dynamics in my narrative? What about my fears of maternal engulfment? What about my need for a defense against my fears of maternal engulfment? What about looking at how my reaction to the therapist (in the form of criticism, feelings of being overwhelmed by her, feeling like an infant who is being force-fed, feelings that she is self-interested and exploitive (concerned only with her own narcissistic injury) all elaborate aspects of my internal working model that relate back to my relationships with early attachment figures? (Recall Kohut's observations about one of his patients: "The patient's object hunger, his idealizing merger needs were fixations on archaic pre-oedipal forms deriving from deficits emerging out of his relationship with *an engulfing mother who used him for her own selfobject needs.*" Am I not projecting those very qualities onto the therapist?) Strikingly, following my twenty-minute soliloquy, the therapist's first reaction was not feedback at all – it was, in fact, a *question* and a series of self-interested statements: "*Why don't you just talk to a wall? You don't need a therapist. You might as well just talk to a wall! I need to give feedback!*" One might inquire: Where was the feedback? Where *was* the feedback? At another point, the therapist said: "No other therapist would stand for this!" (Does she see herself as superior to all other therapists?) And the following: "*Even dynamic therapy focuses on the relationship. You say you don't want a relationship with me, but at other times you talk about having a relationship with me.*" "*You don't seem to know what you want.*" "*I won't react angrily because that wouldn't establish trust.*"

The statement “No other therapist would stand for this” is noteworthy. It’s a black-and-white, or all-or-nothing, statement. The fact that the therapist was regressing at this moment in the session to a (paranoid-schizoid) anxiety state can be shown by reference to a passage from one of my previous letters:

Interestingly, several sessions ago, the therapist said in another context, “Are you always right?”

Let's look at those two statements :“You think you're smarter than everybody else.” “Are you always right?” Notably, both statements are black and white statements or “all or nothing” statements, suggestive of splitting. It is recognized that individuals can regress to a state of splitting in response to anxiety, that is, in response to feelings of being threatened. Anxiety causes individuals to revert to paranoid-schizoid thinking which defends the self by the dichotomous splitting of ideas into good and bad (or all or nothing), thereby holding onto good thoughts and feelings and projecting out the bad. Unconscious splitting avoids the troubling nature of what learning may actually involve, so that a lack of appreciation of the complexity of the whole object vitiates the emergence of complex solutions and promotes the emergence of simplistic “quick fixes.”

Hirschhorn, L. The Workplace Within: Psychodynamics of Organizational Life.

Note also the projective aspect of the statement: “You don’t seem to know what you want.” As I pointed out at the outset, it was the therapist herself who recommended that I stop writing letters and instead tell her directly what troubled me about her work. I followed her recommendation, and she attacked me for doing what she herself suggested I do! *Does the therapist know what she wants?*

I am intrigued by the borderline quality of the therapist’s reaction to me.

In asking me why I was in therapy at all, she reminded me of the borderline patient: *You hurt my feelings. I hate you! I don't want to see you again! Why are you even here with me? You say you want to be my friend, but you don't act like a friend! You don't seem to know what you want! I hate you!*" I suspect that the therapist's response of rage-humiliation-indignation resulted from my assault on her idealized self-concept as a nurturing, empathic, and caring therapist. My critical comments about her called into question her role as a mother who feeds the infant. It is as if she were saying, "You won't accept my breast. You have a duty to accept my breast. I feed you. You don't feed me. You are the infant. Infants don't feed the mother. Patients don't lecture the therapist on her technique – I will not allow you to force your nipple into me!"

But note well: Dismissive avoidant patients are not desperately concerned about issues of trust, closeness, and the dependability of others, or about their capacity to love and express affection. They do not express exaggerated anxiety about establishing and maintaining interpersonal relationships, including the relationship with their therapist. Dismissive patients do not need to be cared for, loved, and protected. The fact that I don't express these needs is not evidence that I fail or refuse to cooperate with the therapist's technique; the fact that I don't express these needs is evidence that I have a dismissive avoidant attachment style, an attachment style that the therapist has failed to adjust to. "It is recognized that it is important that therapists early adjust their orientation" – based on the therapist's assessment of whether the patient is primarily struggling with relatedness problems or self-related problems of guilt (self-criticism) and identity-definition – "in order to enhance treatment outcomes." Werbart, A. "Matching Patient and Therapist Anacritic-Introjective Personality Configurations Matters for Psychotherapy Outcomes."

One might inquire: How is the therapist adjusting her technique with me

to enhance my treatment outcome?

A note about the therapist's use of the term "feedback." I have a sense that the word "feedback" has special meaning for this therapist. I have the impression that "feedback" isn't simply a therapeutic comment, observation or interpretation that she offers me to think about or consider — rather, "feedback" is given implicitly as a pronouncement "from on high" that I am duty-bound to accept. The therapist becomes noticeably agitated when I present thoughts or reflections about her "feedback." A previous therapist, Stanley R. Palombo, M.D. would ask me, "*any thoughts?*" when he offered an interpretation; he encouraged me to reflect on what he said. At this clinic, it appears that I am not permitted to reflect on the therapist's feedback. *This is a forbidden act.* Imagine a celebrant at mass who says to the priest, "You know, Father, I'm not crazy about this brand of wine." (*Huh?*) The wine is part of a ritual. The celebrant does not comment on the merits of the wine. The celebrant (the "true believer" who accepts the symbolic nature of the ritual) is required to imbibe the wine and thereby experience spiritual transformation. At the clinic, I have the sense that patients are required to "imbibe" the therapist's "feedback" — not reflect on it. There is a ritualistic quality about the clinic's work. But unlike other patients at the clinic, I have not regressed to a state of symbiotic merger with the therapist (like infant with mother); I am not a "true believer" who involuntarily or unconsciously acquiesces in the symbolic nature of the clinic's therapeutic protocols, which are, in fact, ritualized. There is confirmation for these speculations. In a paper on the *ritualization* of therapy at a particular clinic, the author observes: "Despite the management team's clear view that decisions about care should be part of a collaborative process between patient and staff, the institution continued to refer to 'feedback' that was handed over to patients following meetings, similar to an *ex cathedra* pronouncement from on high. In other words, anxiety about thinking together led to a ritualization of

communication that generated further anxiety and pushed both patients and staff into ritualized roles.” Wood, D. “Baked Beans and Mashed Potato: The Basic Assumption of Incohesion:Aggregation/Massification in Organizations Treating Adolescents with Eating Disorders.”]

PATIENT [continuing]: “Are you saying I am a difficult patient? Dr. Palombo said . . .” (This comment seemed to spark the therapist’s envy.)

THERAPIST [cutting me off angrily]: . . . I am not saying you are a difficult patient!

[Additional therapeutic give-and-take.]

[At the conclusion of the session, the therapist made statements that suggested to me she was reacting to the emergence of depressive anxiety. She engaged in a kindly gesture: “It’s raining. You can wait here for a while till the rain stops.” – “No I have an umbrella.” “I want you to have a nice vacation.”]

PROBLEMATIC ASPECTS OF THE THERAPIST’S WORK

— It is problematic for the therapist to base her entire intervention program solely on attachment-related principles. The therapist emphasizes her need to provide an attachment-based “emotionally-corrective experience” without regard for introjective aspects of my personality problems. See Dubois-Comtois, K. “Attachment Theory in Clinical Work with Adolescents.” “Clinicians should . . . refrain from basing their entire intervention program solely on attachment-related principles.” “Specific attachment-based intervention should only be conducted when the clinician suspects that it is related to the [patient’s] main issue with regards to [social] maladaptation. In most cases, attachment-based

intervention should be used in conjunction with other intervention strategies.”

- It is problematic for the therapist to fail to modify her technique to suit the needs of my introjective personality. It is recognized that it is important that therapists early adjust their orientation — based on the therapist’s assessment of whether the patient is primarily struggling with relatedness problems or self-related problems of guilt (self-criticism) and identity-definition — in order to enhance treatment outcomes. Werbart, A. “Matching Patient and Therapist Anaclitic–Introjective Personality Configurations Matters for Psychotherapy Outcomes.” “Introjective depression, based on the sense that “I am a failure,” responds to classical psychoanalysis, *with the therapist as a listener*, helping to elicit growth in an independent sense of self. Anaclitic depression, based on the feeling that ‘I am not worthy of love,’ is effectively treated by a more assertive therapist, guiding the formation of relationships.” It is problematic for the therapist to deny the extent to which my introjective problems actually impair my ability to form relationships. My problem is not simply the absence of relationships but the presence of introjective issues. It is recognized that the development of interpersonal relations is interfered with by exaggerated struggles to establish and maintain a viable sense of self.
- It is problematic for the therapist to deny her responsibility to act as a *patient listener* to effect therapeutic change of my introjective problems and to assert, instead, that she must employ the role of “assertive therapist” to “[guide] the formation of relationships. See Werbart, A., above.
- It is problematic for an attachment-based therapist to censor the patient’s reports about his feelings of discomfort in relation to the therapist, preventing the emergence of clinical material that elaborates the

patient's internal working model that, in my case, involves fears of maternal engulfment as well as the narcissistic need for twinship, idealization, and mirroring.

-It is problematic for the therapist to censor the patient's expression of the "negative transference." Working through the transferred feelings is an important part of psychotherapy. The nature of the transference can provide important clues to the patient's issues, and working through the situation can help to resolve deep-rooted conflicts in the patient's mind.

-It is problematic for the therapist to deny the specific clinical presentation of an introjective patient, for whom the meaning of things is especially important. Valdez, N. "Verbal expressions used by anaclitic and introjective patients with depressive symptomatology: Analysis of change and stuck episodes within therapeutic sessions." "It is problematic for the therapist to deny the patient's need to address his concerns about maintaining a definition of the self ("I am a fish, not a dolphin.").

Introjective patients have distinct non-relational concerns that involve a "range from a basic sense of separation and differentiation from others ("I have mixed feelings about being different from other people"), through concerns about autonomy ("I get an ego boost out of being different from others") and control of one's mind and body ("I feel as if you're trying to force me to be sociable"), to more internalized issues of self-worth ("So I heard him say, 'See that guy over there, that's Freedman. You could hear a pin drop in class when he speaks'"), identity, and integrity. The development of interpersonal relations is interfered with by exaggerated struggles to establish and maintain a viable sense of self. Introjective patients are more ideational ("You didn't distinguish between the different attachment types"), and issues of anger and aggression (as in expressing feelings of confusion and frustration with the therapist), directed toward the self or others, are usually central to their difficulties." Blatt, S.J and Shahar, "Psychoanalysis-With Whom, For What, and

How? Comparisons with Psychotherapy.” It is problematic for the therapist to fail to recognize that an introjective patient will have more fully-developed cognitive processes than patients who are concerned with social relatedness. It is problematic for the therapist to fail to support an introjective patient’s need to think primarily in sequential and linguistic terms as well as analyze, critically dissect, and compare details.

-It is problematic for a therapist to fail to support an introjective patient’s associative capacities and insist that her need to provide feedback makes the support of his associative capacities inappropriate.

Psychodynamically-informed treatment “was found to contribute significantly to the development of *adaptive interpersonal capacities* and to the *reduction of maladaptive interpersonal tendencies*, especially with more ruminative, self-reflective, introjective patients, possibly by extending their associative capacities. Supportive-Expressive Psychotherapy, by contrast, was effective only in reducing maladaptive interpersonal tendencies and only with dependent, unreflective, more affectively labile anaclitic patients, possibly by containing or limiting their associative capacities.” Blatt, S.J and Shahar, “Psychoanalysis-With Whom, For What, and How? Comparisons with Psychotherapy.” According to the authors, limiting patients’ associative capacities will promote therapeutic change only in relationally-oriented patients; conversely, limiting patients’ associative capacities will *impair* therapeutic change in introjective patients.

-It is problematic for an attachment-based therapist to fail to recognize that “[p]atients with a dismissive-avoidant attachment style (introjective patients) respond best to psychodynamically oriented interpretive therapy. Emotionally detached, isolated, avoidant, and wary introjective patients, who tend to recall more family conflicts and who view relationships with others, including the therapist, ‘as potentially hostile or rejecting’, found the exploratory emphasis in [interpretive therapy] liberating and

conducive to therapeutic change.” Blatt, S.J and Shahar, “Psychoanalysis-With Whom, For What, and How? Comparisons with Psychotherapy.”

-It is problematic for the therapist to moralize about my failure to present the classic personality problems of so-called anaclitic patients who are dominated by concerns about interpersonal relatedness. Anaclitic patients tend to ask their therapists for more feedback as a way to be understood by them. The anaclitic patient’s receptivity to the therapist’s feedback may be an automatic response that may not necessarily signify that he is making conscious efforts to be compliant with the treatment process. Anaclitic patients are always desperately concerned about issues of trust, closeness, and the dependability of others (including therapists), as well as about their own capacity to love and express affection. They express exaggerated anxiety about establishing and maintaining interpersonal relationships, including the relationship with their therapist. These patients need to be cared for, loved, and protected. The fact that I don’t express these needs is not evidence that I am actively noncompliant with the therapist’s technique. My response is largely an automatic response dictated by my dismissive personality style.

-It is problematic for the therapist to fail to recognize the counter-transferential nature of stigmatizing, black-and-white interventions, such as, “Why don’t you talk to a wall?” (in response to my communicating negative comments about therapy), “Do you think you are always right?” (in response to my questioning why the therapist seemed to ignore issues in my trauma history), “No other therapist would stand for this!” (in response to my talking about feelings of confusion and frustration in reaction to the therapist) and “You think you’re smarter than everybody else!” (after I mentioned that I had received an email about attachment theory from a university professor).

– It is problematic for an attachment-based therapist to fail to consider the possible defensive aspects of a therapeutic technique that, to some degree, might rationalize a therapist’s possible “preoccupied attachment” style. It might be productive for an attachment-based therapist to inquire into the possible irrational element in a technique that places inappropriate demands on an introjective/dismissively avoidant patient for emotional closeness and approval in which the therapist’s unconscious concern, “I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like” translates in the clinical situation to *“This patient just doesn’t want to get close to me”*; the therapist’s unconscious concern “I am uncomfortable being without close relationships” translates in the clinical situation to *“I am uncomfortable with patients who don’t want to be emotionally close to me”*; the therapist’s unconscious concern “I sometimes worry that others don’t value me as much as I value them” translates in the clinical situation to *“This patient doesn’t value me. I become angry when I feel that a patient criticizes me. I am emotionally unable to work with a patient’s negative transference.”* Does a therapist’s possible attachment insecurity that centers on the need for a high level of intimacy, approval, and responsiveness from her attachment figures translate in the clinical situation to inappropriate demands being placed on a dismissive-avoidant (introjective) patient for emotional intimacy and approval?

MY PERCEPTION OF THE THERAPIST AS A CULT LEADER

Is it possible that my therapist’s model of treatment is not a psychotherapy model? Might it be something else? Arguably, the model she employs is based on the relationships found in cults or religious institutions. Her dyadic therapy relationships are, in practice, seemingly based on a model that views the therapist as cult leader (or priest) and the patient as a cult follower (or “true believer”).

This notion finds support in the work of Daniel Shaw who describes some therapy relationships as “cult-like” – a cult of two.

Daniel E. Greenberg, Ph.D. has written: “Shaw’s analysis of the traumatic assault on subjectivity in cults [and in some therapy relationships] lays the foundation for his approach to the problem of the origins and perpetuation of social oppression and injustice. Shaw aligns himself explicitly with Eric Fromm’s work on the “escape from freedom,” a social psychological process in authoritarian and democratic regimes [and in some therapy relationships] in which individuals [or therapy patients] are induced to sacrifice their autonomy and subjectivity. Fromm explored, ‘both the mind and motives of the traumatizing . . . narcissist [leader or therapist] as well as . . . the individual [or therapy patient] who escapes from freedom by idealizing and submitting to *infantilizing*, controlling others [as represented by some therapists].’” (p. 56).

The following regressed psychodynamics found in the so-called “homogenized group” are dominant in cults: “The homogenized group is the most primitive and regressed collective response to basic (annihilation) anxiety. Its predominant characteristic is the lack of self-object differentiation, where 'normal autism' and 'symbiosis' persist as developmental forerunners to the earliest separation-individuation phase. Individuation is absent. Similar to the nascent self of the infant who is merged with and anxiously attached to the love object, mother, individual members of the homogenized group are as one. Members experience unusual difficulty in distinguishing between self and other and have great difficulty in achieving meaningful interaction with each other. Such primitive conditions symbolize infantile regression. Group members are cut off from external object relationships and become detached and withdrawn. A shared collective unconscious wish to return to the safety of the womb to avoid the group's hostile environment is realized by group members in this culture. Members often experience the same feelings and

act similarly, an illusion of security in a culture of sameness." Diamond, M.A. and Allcorn, S. "The Psychodynamics of Regression in Work Groups." *Human Relations*, 40(8): 525-554 (1987).

In the cult, the leader infantilizes the followers:

- The follower is denuded of personal identity;
- The follower experiences a state of “oneness” with the leader and other followers;
- The follower is purely a receptacle for the leader;
- The follower’s only task is to imbibe the dogma of the leader;
- Happiness is membership in the cult based on a relationship of subjugation; the ultimate terror for the follower is ejection from the cult;
- The only emotional pain experienced by the follower is disapproval by the leader;
- The follower *may not* question or criticize the leader.

I call this infantile because the cluster parallels the mother-infant relationship:

- The infant has no personal identity;
- The infant experiences a state of “oneness” with the mother;
- The infant is purely a receptacle for the ministrations and milk of the mother;

- The infant's sole duty is to imbibe the mother's milk;
- Happiness for the infant is the present mother; the ultimate terror for the infant is maternal absence;
- The only emotional pain of the infant is the absence of mother;
- The infant *cannot* question or criticize the mother;
- The only emotions experienced by the infant are *bliss or happiness* (in mother's presence); *anger or rage* (the screaming or biting infant); *loneliness*; and *fear* (annihilation anxiety).

These dynamics seem to be the model for the therapist's model of treatment:

-The patient has no personal identity. ("Why are you so concerned with psychological testing?" "I don't believe in categories or labels." "Most of the people I work with talk about loneliness and fear of rejection," as if all patients are a homogenized mass.) Does the therapist at some level believe that, ideally, all therapy patients are alike - that they are all ideally somehow "homogenized?" Are there linkages in the therapist's mind between her "need to give feedback," the patient's feared "loss of maternal protection" (i.e., the absent mother and consequent loneliness), annihilation anxiety, the automatic positive affective response of patients to the therapist, and ultimately, the patient's loss of individual identity and the patient's establishment of "oneness" with the therapist, which seems to be the therapist's ideal? I am vaguely reminded of a passage from a text on group dynamics, "Group Psychotherapy for Psychological Trauma," Klein, R.H. and Schermer, V.L., eds.: "The absence of social feedback in large groups evokes feelings of loss of maternal protection; participants often feel there as if they are suffering from a fracture of their personality [annihilation anxiety].

The threat to one's identity experienced in a large group may bring a conversion response of magically feeling at one with the group as a whole; thus, members may come to believe in a homogenization, with absolute sameness of belief and no role differentiation among members. The leaders of 'oneness groups' are charismatic [like cult leaders?]. Homogenization is the source of oneness."

- The patient is purely a receptacle for the feedback of the therapist;
- The patient's sole duty is to imbibe the therapist's feedback. (Tellingly, the therapist has never asked for my reaction to anything she has ever said. Dr. Palombo used to ask frequently "Any thoughts" after he made an interpretation.);
- The ideal state for the therapist is the magical emergence of "oneness" between patient and therapist;
- Happiness for the patient is the therapist's presence, that is, the experience of a feeling of "maternal protection" or "oneness"; the ultimate fear for the patient is therapist absence or disapproval, i.e., the loss of maternal protection. (Incidentally, Bion pointed out that the present "bad mother" – the disapproving or frustrating mother – is the equivalent of the absent "good mother." Perhaps, one might add that the present "good mother" is the equivalent of the solitary infant's reverie (where that creative capacity exists). It seems to say something about this therapist that she seems to equate a patient's social isolation with the painful affect of loneliness, as if there were a lack of internalization or ego differentiation in this therapist.
- The only emotional pain of the patient is loneliness (that is, the absent

good mother or “the loss of maternal protection”). The therapist is unable to process a patient’s feelings in relation to his “internal objects” (introjective pathology). I suspect that the therapist has difficulty processing the idea of the “present bad mother” (as well as “bad internal objects”) which seems related to her inability to work with a patient’s negative transference. In the paranoid-schizoid position, Bion has remarked that there is no sense of an absent good object –the infant is either in the presence of a good object or, if the mother is *unavailable*, it is in the presence of a bad object.

-The patient may not question or criticize the therapist. Negative transference cannot be processed. Negative transference is synonymous with bad behavior. Criticism of the therapist evidences a lack of the ideal state of “oneness” between the therapist and patient.

-The only emotions experienced by the patient are *happiness* (the presence of a feeling of maternal protection); *anger*; *loneliness*; and *fear*. (“*How do you feel around people*,” she asked. I said, “*I feel a sense of alienation*.” She said, “*Let me show you how that is really fear of rejection*.” “*Most of the people I work with complain about fear of rejection and loneliness*.” The fact is she can’t process “a sense of alienation” because infants don’t experience a sense of alienation. If I tell her I feel frustrated by her, she says, “*you are feeling angry*.” The fact is she can’t process feelings of “frustration” because infants don’t feel frustration. It’s as if she were an artist whose palette only includes the primary colors: red, yellow and blue. Forget about green, orange, violet – forget about any shades of green altogether. It’s simply: you are angry, you are lonely, you are happy, you are afraid.

What I am describing is a style of therapeutic interpretation that encourages infantilization of the patient, the very process that occurs in cults.

THE CLINIC AS CULT

It's my impression that the clinic operates like a cult. I see the cult-like aspect of the clinic in two areas of the operation of the clinic: (1) the therapists' interaction with individual patients as well as (2) the relationships of the therapists in the clinic as an organization.

1. Therapist relationships with patients

It is my perception that the therapists at the clinic (and I am generalizing from my personal experiences with my therapist) engage in infantilizing behaviors with their patients. The patients regress to a state of symbiotic union with the therapists. In this symbiotic state – akin to the relationship of infant to mother – the patients become highly suggestible. The patients accept without question the interventions and worldview of the therapists, like an infant imbibing mother's milk. The therapeutic relationship between therapist and regressed patient is based on the patient's idealization of the therapist.

I see a connection to hypnosis. The patients at the clinic, in their regressed state, accept the therapist's interventions unquestioningly as an individual would accept hypnotic suggestion by a hypnotherapist. The patients become de-differentiated and merge with the therapist. The patient experiences a loss of identity or distinctiveness; in this state, the relationship of the patient and therapist is not collaborative as in a healthy therapeutic relationship, rather the patient becomes a vessel for the therapist's feedback. The patient is not an active, consensual participant in the therapy, but a submissive container – again, like the infant feeding at mother's breast.

I find it telling that when I was in therapy with Dr. Palombo he routinely said to me after an intervention, "Any thoughts?" – he wanted my feedback; for him the patient was an active, consensual participant in the relationship. My therapist has never – never – asked for my opinions about her feedback and seems irritated when I offer them. I sense she thinks I have a duty to internalize her feedback – that is, imbibe her interventions the way an infant imbibes mother's milk (or the cult member is duty bound to accept the wisdom of the cult-leader – or, indeed, the way a celebrant at mass accepts the sacrament of Communion).

At the clinic, patients tend to avoid making unique contributions to the therapy or advocating positions with the therapist; rather they look to the therapist for simple solutions to complex problems. It seems as if any solution offered by the therapist will do as long as it is pronounced by the therapist who is viewed by the patient as an authority figure.

Patients experiencing grief, loss and trauma perceive themselves to be in a psychologically-dangerous situation—one that threatens their internalized self-image, their identity. Such a threat to self-other boundaries and self-concept promotes psychological regression by the patient. In part, the psychological regression is informed by internal representations of self and other and in part it is influenced by actions by the therapist.

Symbiosis in this cult-like therapy situation means the union of the patient with the therapist in such a way as to make him lose the integrity of himself and to make the patient completely dependent on the therapist. The patient gains security by swallowing somebody else, namely the therapist (as the infant swallows mother's milk). The integrity of the individual self is lost and the patient becomes highly suggestible.

Regressive psychodynamics pull the patient into a symbiotic and de-differentiated relationship with the therapist and the symbolic return to the maternal object.

Under the influence of symbiosis, the patient seeks a safe haven in primitive subjective (pre-oedipal) states of imagined union with the therapist as a maternal object. Consequently, self-object differentiation is obliterated along with innovation, creativity, and independence.

A creative, innovative, and independent-minded patient will have serious problems in such a cult-like atmosphere.

Support for these speculations comes from observations about group dynamics. In groups there is a collective regression by group members. Members react to their anxieties in the work group by denying their individual differences (distinct identities) and psychologically merging with each another. This is a common form of regressive withdrawal among group members under stress that threatens participation, consensual decision-making, learning and effectiveness. Diamond, M.A., "The symbiotic lure: organizations as defective containers."

Group members tend to avoid making unique contributions or advocating positions~often looking to the leader or leaders for the simple solution to a complex problem. It seems as if any solution will do as long as it is pronounced by someone in a position of authority and quickly agreed to and supported by everyone else. See, Diamond, M.A.,

Group members experience psychological threat under the pressures of group life (annihilation anxiety) and perceive themselves to be in a psychologically-dangerous situation ~ one that threatens their internalized

self-image, their identity. Such a threat to self-other boundaries and self-concept promotes psychological regression. In part, the psychological regression is informed by internal representations of self and other and in part it is influenced by organizational and managerial actions at work. See, Diamond, M.A.

Symbiosis in groups means the union of one individual self with another self (or any other power outside of the own self) in such a way as to make each lose the integrity of its own self and to make them completely dependent on each other. The sadistic person needs his object just as much as the masochistic needs his. Only instead of seeking security by being swallowed, he gains it by swallowing somebody else. In both cases, the integrity of the individual self is lost. See, Diamond, M.A.

Regressive psychodynamics pull group members into symbiotic and de-differentiated relationships and the symbolic return to the maternal object. See, Diamond, M.A.

Under the influence of the symbiotic lure, group members seek a safe haven in primitive subjective (pre-oedipal) states of imagined union with the maternal object (often symbolized by the organization and its leaders). Consequently, self-object differentiation is obliterated along with innovation, creativity, and independence. See, Diamond, M.A.

2. Cult-like dynamics of the clinic

I suspect that therapists at the clinic experience intense anxieties working with patients struggling with grief, trauma and loss. The clinic as an organization can, in such a circumstance, serve as a social defense against anxieties. In the therapists' relationships with each other and their

relationship with the clinic director, the clinic as an organization dissipates therapists' anxieties in the same way the cult-like patient-therapist relationships at the clinic dissipate patient anxieties. Just as patients defend against internal threats through regression and dedifferentiation, the therapists themselves defend against the anxieties of their work through *symbiosis* with the clinic as an organization as well as *dedifferentiation* of individual therapists' identities. Such dedifferentiation of therapists tends to ensure that the numerous therapists are uniform in their treatment approaches.

Support for these ideas comes from the work of group theorist, Isabell Menzies-Lyth. Menzies-Lyth formulated a way of thinking about social structures as forms of defense – as ways of avoiding experiences of anxiety, guilt, doubt and uncertainty. She believed that the individual is engaged in a lifelong struggle against primitive anxiety.

In her classic paper on nursing, she writes: "By the nature of her profession the nurse [like the grief counselor] is at considerable risk of being flooded by intense and unmanageable anxiety." Nursing "work arouses strong and conflicting feelings: pity, compassion and love; guilt and anxiety; hatred and resentment of the patients who arouse these feelings; envy of the care they receive." The organization and bureaucratization of nursing work in hospitals serves as an organizational defense against the anxieties raised by caring for people in life and death situations. By establishing a rigid hierarchy, fixed psychological roles and a routinization of work, the hospital was able to diffuse responsibility and anxiety from the individual nurse to the system as a whole. That benefit came, however, at a cost: the use of the primitive defenses of splitting, denial and projection prevented more mature forms of coping with anxiety to emerge, and thus stifled individual growth.

One group theorist has talked about how the social defense system employed by teachers can promote de-differentiation, or loss of individual identity, among the teaching staff: "Since the operative social defense system in schools is not criticizing each other, teachers wanted unity, equality and control. What characterized good relationships between colleagues, they said, was the fact that they were (quote) 'similar as people.' For instance, that they had the same 'problems with students,' the same 'way of handling conflicts,' the same 'way of thinking' or they felt similar because they were in the same situation, for instance 'new at school,' 'the same age,' had 'the same sense of humor,' were 'interested in the same things' and that sort of thing. Many teachers often called being similar 'getting on well together.' They felt, then, that this was important in order to be able to work well together. And even though this can be seen as being in contrast to the ideal of 'being oneself,' it is understandable in light of the defense system of avoiding the feeling of criticism." Ramvi, E. "What Characterizes Social Defense Systems."

The question that comes to my mind is how the de-differentiation process operating among teachers (that is, the social defense system employed by the teachers) filters down to students in the school and results in teachers treating the students as a homogenized class, that is, it results in the teachers not seeing the students as having individual identities.

What I am saying is that perhaps the de-differentiation process operating among the mental health clinic's therapists (that is, the social defense employed by the therapists) promotes behaviors by the therapists in relation to individual patients that promotes de-differentiation among the patients and, in turn, is a driver of infantilization by patients. Let me repeat an observation from earlier in this text: *"The patient experiences a loss of identity or distinctiveness; in this state, the relationship of the patient and therapist is not collaborative as in a healthy therapeutic relationship, rather the patient becomes a vessel for the therapist's feedback. The patient is not an active,*

consensual participant in the therapy, but a submissive container – again, like the infant feeding at mother's breast." I have sensed this strongly at my mental health clinic where my therapist talks in generalized ways about her other patients: "my other patients talk about loneliness and fear of rejection" or "my other patients come here with concrete goals that they want me to help them with." Or "I am not interested in the psychological test results" that stamp you as a unique person with unique problems. Even the use of CBT technique can be seen to serve the defensive purpose of de-differentiation for therapists at the clinic. CBT practitioners believe that mental patterning is responsible for pathology insofar as it both constructs subjective experience and organizes behavior, by processing inner and outer sensory perception in an *idiosyncratic* way. CBT emphasizes the patient adopting factually accurate or realistic mental schemas and avoids the therapist collaborating with the patient in a psychodynamic exploration of the patient's *unique* or *idiosyncratic* wishes, fantasies, conflicts and prohibitions.

One might inquire: Is the clinic's work driven by the patients' needs – or is the clinic's work, in fact, ultimately driven by the defensive needs of the therapists themselves, namely, their need to ward off the intense anxieties associated with working with patients who are struggling with grief, loss and trauma as well as their need for effective and uniform team-work.

One might say that the therapists at the clinic look to the organization as a whole to diffuse anxiety that parallels the way the patients look to the individual therapists to diffuse the primitive anxieties associated with loss, grief and trauma. Indeed, Sandra Bloom sees a close parallel between the work anxieties experienced by trauma care providers and the trauma-associated anxieties experienced by trauma survivors: "The social defense mechanisms created by mental health systems sound uncannily like those that we see in victims of trauma – depersonalization, denial, detachment, denial of feelings, ritualized task-performance, redistribution of

responsibility and irresponsibility, idealization, avoidance of change."
Bloom, S.L. and Farragher, B. "Destroying Sanctuary: The Crisis in
Human Service Delivery Systems."

I suspect that there is a parallel process at the clinic in which
therapist:clinic *equals* patient:therapist.

Therapy Session: August 14, 2018

I. INABILITY TO WORK WITH FIGURATIVE REPRESENTATIONS ~ INABILITY TO WORK WITH GIFTED PATIENT

It has been observed that the unexpected quality of novel metaphors appeals to creatively gifted individuals given their proclivity for language and imagination. The unexpected connections that comprise metaphor manifest the creative process and can give rise to innovative expressions and concepts. Creatively gifted individuals have an extraordinary facility with metaphor, using these expressions in ways that reveal advanced metalinguistic ability. In addition, the metaphors they create reflect a wealth of ability from profound *emotional and spiritual dimensions* to playful and humorous insights into the human condition. Fraser, D.F.G. "From the playful to the profound: What metaphors tell us about gifted children."

At one point in the session I reported: "I feel like an exile. I told you I wrote a book. Some of the characters are political exiles [from Iran]."

At a later point I reported: "I feel like an extra-terrestrial alien plopped down on planet Earth. I feel like I have nothing in common with humans and I yearn to get back to my home planet, get back to my people."

The therapist responded: "How about if we look at that in a different way. Let's say you're not from another planet. Let's say you're from Earth and that you yearn to interact with other people."

There are multiple problems with the therapist's response (or distortion).

DENIAL OF INTERGENERATIONAL TRAUMA

1. The therapist is aware of my family background. I have talked about my immigrant background: the fact that my grandmother was an immigrant from Poland, that she spoke poor English all her life, that she never assimilated into American culture. Also, at this session I explicitly talked about the issue of "immigration" from another country and the status of "exile." Clearly, the metaphor about extraterrestrial aliens related to the issue of exile (and by implication, my immigrant family background.) The clinical material taken together is suggestive of problems of the intergenerational transmission of trauma. See, e.g., Portney, C. "Intergenerational Transmission of Trauma: An Introduction for the Clinician."

FAILURE TO RECOGNIZE A POSSIBLE SYMPTOM OF COMPLEX TRAUMA

2. Complex trauma is often defined as long-term, interpersonal abuse, occurring on multiple occasions and often beginning early in life (Herman, 1997). Complex trauma can lead to alterations in self-perception, including the following well-known symptom: a sense of complete difference from others, which may include a sense of specialness, utter aloneness, a belief that no other person can understand, or *feelings of having a nonhuman identity*. My extra-terrestrial alien metaphor – my feeling that I am utterly different from others – specifically that I feel like an "alien" suggests my assumption of a non-human identity, consistent with complex trauma.

The failure of the therapist, who works with trauma patients, to inquire into my report about an alien identity, and instead go on to invalidate that report ("Let's say you are a human on earth rather than an alien"), is troubling.

FAILURE TO RECOGNIZE A CLASSIC SYMPTOM OF SCHIZOID PROCESS

The therapist is aware that I have a significant schizoid trend in my personality. On the MMPI I scored T=85 on the Schizoid Scale; scores greater than T=65 are statistically significant on the MMPI. Schizoids feel so alienated and different from others that they can experience themselves literally as alien—as not belonging in the human world. Yontef describes a patient from Argentina who quoted a saying in Spanish that describes her experience: She feels like a "frog who's from another pond." Yontef, G. "Psychotherapy of Schizoid Process." Masterson states that describing oneself as "alien" is a "classic" schizoid symptom. Masterson, J.F. *The Personality Disorders: A New Look at the Developmental Self and Object Relations Approach* at 134.

PROJECTION

3. The therapist denied the issue of intergenerational trauma and transformed the ET metaphor into a situation in which I was struggling with approach avoidance typical of a fearful avoidant attachment style. "You are like everybody else; it is your fear of other people that is the problem." In fact, my attachment style is "dismissive avoidant" (introjective) and not fearful avoidant (anaclitic). The therapist has shown in several sessions that she is either unaware of the dynamics of dismissive avoidant attachment style/introjective pathology or intentionally refuses to deal with this issue. She gives the impression that she has a defensive (projective) need to view me as a fearful avoidant/anaclitic, rather than a dismissive avoidant/introjective, that is, that I have significant narcissistic disturbance that involves a pathological need for mirroring, twinship and idealization. The therapist consistently denies my ego deficits and focuses exclusively on fear and the lack of interpersonal connectedness. May we perhaps see the therapist's skewed focus as an example of infantilization? Infants do not struggle with ego

deficits; infants struggle with annihilation anxiety (fear) and a need for connectedness.

INTELLECTUALIZATION/PROJECTION

4. At one point in the session, the therapist talked about my use of intellectualization to avoid feelings of emotional vulnerability. The therapist's interpretation is itself suggestive of intellectualization. She treated my ET metaphor as an intellectual construction that she could freely manipulate without altering the *affect* underlying the metaphor. In the therapist's intellectualized transformation, the metaphor was denuded of any anxiety centering on intergenerational trauma, complex trauma, feelings of alienation, and yearning for self-object experiences (as represented by my fellow "aliens" from another planet).

5. At one point I talked about my special need for autonomy, that I place a premium on autonomy over interpersonal relatedness. The therapist responded that my thoughts about autonomy suggested "all or nothing" thinking. It's as if the therapist were saying, "You *think* you need to be autonomous, but you don't need to be autonomous. That simply reflects a cognitive distortion on your part." Again, the issue is not the intellectualized problem of "thinking." The pertinent issue is a personality trait. Creative persons have a special "desire to be different from others" that is associated with a sense of independence, anti-conformity, inventiveness, achievement, and self-esteem. Snyder, C. R. & Fromkin, H. L., "Abnormality as a positive characteristic: Development and validation of a scale measuring need for uniqueness." The therapist consistently transforms my reports that contain important clues about my *feelings* and personality characteristics into intellectualized constructs that can be manipulated at will.

I note also that in one way or another we all struggle with the conflict between a need for autonomy and a need for social relatedness. The

therapist herself is Clinical Director, a leadership position. What does it say about the therapist that she doesn't see that my need for autonomy might be a leadership quality? What does it mean where an individual in a leadership position in an organization, such as the therapist, seems to be dominated by a "fear of extrusion" (loss of relatedness) rather than a "fear of engulfment" (a need for autonomy)? Kernberg has thoughts about that very issue. I refrain from referencing them. Kernberg, O.F. *Ideology, Conflict, and Leadership in Groups and Organizations*.

DENIAL THAT I BELONG TO A REFERENCE GROUP - DENIAL OF IDENTITY - ANAL SADISM

Chasseguet-Smirgel saw anal sadism as driving the need to see individuals (or any objects that have a specific identity) as indistinguishable from each other. In her essay "Perversion and Universal Law" Chasseguet-Smirgel refers to "an anal universe where all differences are abolished . . . All that is taboo, forbidden, or sacred is devoured by the digestive tract, an enormous grinding machine disintegrating the molecules of the mass thus obtained in order to reduce it to excrement." In the anal universe Good and Evil are synonymous. Shengold seems in accord: "'Anal defensiveness' involves a panoply of defenses evolved during the anal phase of psychic development that culminates with the individual's power to reduce anything meaningful to 'shit'—to the nominal, the degraded, the undifferentiated." Shengold, L. *Soul Murder: The Effects of Childhood Abuse and Deprivation*.

"Chasseguet-Smirgel's interpretation of anal sadism as the de-differentiation of the object by alimentary reduction does not fully elaborate the function of anal sadism for the self in relation to other. Her analysis emphasizes only one side of the sadistic act. The act aims not only at de-differentiating the self: the self imagines that in reducing the other it is establishing its own identity. Because it imagines that in digesting the other it is nourishing its own identity, its effort to gain control over the other

actually represents an effort to separate, to achieve its own autonomy. The paradigmatic other who is being reduced is the mother, from whom the sadist feels unable to separate." Benjamin, J., *Like Subjects, Love Objects: Essays on Recognition and Sexual Difference*.

I note, incidentally, that according to Dorpat, a major and probably universal motive for gaslighting is the victimizer's need to regulate his/her feeling states by controlling (or "gaining control over") interactions with other individuals. Dorpat, T. L. "On the double whammy and gaslighting." *Psychoanalysis & Psychotherapy*, 11(1), 91-96 (1994). See paragraph IV, below.

6. In my ET metaphor I depict myself as belonging to a reference group: fellow aliens from another planet. That is, I am saying there are other individuals like me, a class of "persons," with specific characteristics. In the therapist's representation I am simply a single deviant human. The only valid group is socially-adjusted humans. There is no such thing as a class of persons who resemble me. I need to assimilate into human society—that is, I need to homogenize, as in a oneness group or cult. I see the therapist's procedure as essentially denying me a recognized identity. It would be like identifying a black person as a "non-white" rather than acknowledging him as an African-American who belongs to a class of similar persons who share a common history and cultural identity. When I talked about the fact that I have a high level of autonomy, she interpreted that as pathological. I pointed out that, in fact, there is a reference group to which I belong. I pointed out that it is recognized that gifted persons tend to have a high level of autonomy. This triggered the therapist's rage. It was at this point that the therapist said to me: "You think you're smarter than everybody else!" (Note that earlier in the session the therapist had said at various points, "You are very smart" and "You are a very smart man.")

I am reminded of comments I made at a previous session: "You know, I

feel like I'm a dolphin and you think I'm a fish. Let's say you don't even know what a dolphin is. And the only category you can put me in is fish. So I am a fish to you. Then I do things like surface for air and you think, "Why does he do that? Fish don't surface for air." Well, I'm not a fish! That's why. You create a disturbing situation for me by forcing me to be somebody I am not." In the dolphin metaphor I am saying that I feel the therapist views me as a deviant fish only: that she fails to recognize that I belong to a reference group of similar creatures, namely dolphins, creatures with distinct qualities and needs.

See, Grobman, J "Underachievement in Exceptionally Gifted Adolescents and Young Adults: A Psychiatrist's View." "The need for autonomy developed early and remained an important part of their personality. These exceptional young people wanted control over all aspects of their personal life. They were frequently described as headstrong and oppositional. From the earliest years, they had an intense desire to do things on their own and in their own way, and they balked at interruptions or offers of help. One father recalled that his son was the only one in his grade-school class who refused to start his sentences at the margin. [Compare me: In kindergarten I was the only student who refused to participate in a class project which would require me to subsume my personal identity into a group identity. I refused to make a costume for a school presentation like the other children.] A mother reported an incident from her daughter's sixth year. When a piece of glass had to be removed from the child's foot, the girl was more concerned about being restrained and losing her 'personal freedom' than about the anticipated pain from the procedure."

CONSISTENT PATTERN OF DISTORTION

7. The therapist's distortion of my clinical material at this session parallels her previous distortions of similar clinical material:

At the first consult the therapist asked: "What do you feel around people?" I said I felt alien. She responded: "Many of the people I work with talk about loneliness and fear of rejection." Here, the therapist imputes to me qualities of fearful avoidant/anaclitic pathology.

At a later session I reported that I had feelings of alienation. The therapist responded: "Let me show you how that is actually a fear of rejection." The therapist was imputing feelings of shame to me. That is, "you feel different from other people and because of that feeling you are worried that people will not like and accept you." The therapist associates individuality (or autonomy) with shame and seems unable to process the idea that a person might view being different as a positive distinction. Note also the quality of intellectualization in the therapist's statement. The therapist denied the *affect* of "feelings of alienation," treating that *feeling* as if it were simply a *thought* that could be manipulated like an idea. A *feeling* of alienation is a *feeling* and not a thought.

II. INAPPROPRIATE USE OF DIRECTIVE TECHNIQUE

8. At another point in the session, the therapist embarked on a highly directive approach. She began to ask question after question, and at one point said, "work with me." Directive technique has been found to be counter-productive with introjective patients. That is, the therapist's inappropriate use of directive technique will actually inhibit progress in therapy, not enhance it. To what extent am I failing to make progress in therapy precisely because the therapist is using inappropriate technique?

Persons with predominantly dependent (anaclitic) personalities are characterized by interpersonal dependency and strong wishes to be loved and protected. Depressive complaints are marked by feelings of helplessness, weakness, and intense fears of being abandoned. Persons with a predominantly self-critical (introjective) personality on the other hand are more focused on achievement and living up to their own high

standards and expectations. Depressive complaints are more related to the experience of failure to live up to these standards and feelings of inferiority and guilt.

Different mediators of change are at work in dependent (anaclitic) and self-critical (introjective) patients. Directive interventions seem to alleviate depressive symptoms in dependent patients because the structure and support positively affect the interpersonal functioning of the patients; explorative (psychodynamic) interventions appear to alleviate depressive symptoms in self-critical patients because they promote intrapersonal insight. Further analysis even suggests that explorative approaches might *inhibit* therapeutic progress in dependent patients, because they experience the lack of directedness as a lack of support. Similarly, directive approaches might *inhibit* progress in self-critical patients, because they experience the therapist's directedness and structure as coercive.
Meganc, R. "The Ghent Psychotherapy Study (GPS) on the differential efficacy of supportive-expressive and cognitive behavioral interventions in dependent and self-critical depressive patients: study protocol for a randomized controlled trial."

III. POSSIBLE SUPEREGO ISSUES/ANAL SADISM

9. At one point in the session I pointed out that at times the therapist has said things that I don't understand. I gave an example. "You have used the phrase, 'You need to take risks with people' several times. I have no idea what that even means. What does that mean? I have no idea what that means." The therapist did not answer. She remained silent and expressionless. I formed the impression that she refused to answer my question – or perhaps was unable to answer. I offer speculation. Is it possible that the therapist has a tendency to use clichés or formulas that have no depth meaning for her? Is it possible that she simply repeats commands that she has internalized, terms that she does not fully understand?

I am reminded of Grunberger's observations about one type of superego disturbance. Grunberger talks about a certain personality type that is characterized by a lack of ego homogeneity, a split ego that encompasses a distinct sadistic trend as well as a capacity simultaneously to be a good member of the community, an affectionate spouse, and an exemplary parent. The specific regression also affects his superego, which is an incomplete construction based on different superego formations, each corresponding to a different and overlapping phase in its development. The principal part is played by a precociously formed superego which is based not on the introjection of complete objects but on their *educative function*. It pertains to a training role, which is represented in the unconscious by the introjection of an anal phallus. The pregenital superego is characterized by its severity and does not lead to a real identification. It is made up only of *commands* and prohibitions.

One wonders whether the therapist's statement: "You need to take risks with people" is just such a command. One wonders also whether an unstated prohibition for the therapist is "A patient may not critique a therapist" or "a child may not criticize a parent."

A word about the therapist's occasional use of CBT technique: Keep in mind that CBT is a manualized therapy. The CBT practitioner has internalized a collection of commands or precepts. "If the patient has a pessimistic thought, provide an alternative optimistic thought." "If the patient was abused, reassure the patient that the abuse was not her fault." These precepts are enforced rigidly by the therapist without regard to the meaning or value of any particular intervention. It's the same dynamic we see in authoritarian personalities, who are people who have internalized commands or precepts without any regard to the meaning or value of the command. "It is wrong to question authority. Period." But what if the authority is corrupt? What if the authority is incompetent? What if the authority is malevolent? These are all irrelevant considerations to the

authoritarian personality, since that person has simply internalized the bare precept, "It is wrong to question authority." In some CBT practitioners, we find a tendency to implement precepts outlined in a treatment manual without regard to the specifics of the patient's particular circumstances.

IV. POSSIBLE GASLIGHTING

Gaslighting is a form of psychological manipulation that seeks to sow seeds of doubt in a targeted individual or in members of a targeted group, making them question their own memory, perception, and sanity. It can be an indoctrination technique used intentionally in cults and is used by some therapists either intentionally or unconsciously. Gaslighting and other methods of interpersonal control are often used by mental health professionals because they are effective for shaping the behavior of other individuals. Gaslighting depends on "first convincing the victim (or patient) that his thinking is distorted and secondly persuading him that the victimizer's (or the therapist's) ideas are the correct and true ones." According to Dorpat, a major and probably universal motive for gaslighting is the victimizer's (or therapist's) need to regulate his/her feeling states by controlling interactions with other individuals (or patients) – thereby restricting the other individual's autonomy. Dorpat, T. L. "On the double whammy and gaslighting." *Psychoanalysis & Psychotherapy*, 11(1), 91-96 (1994).

Dorpat views gaslighting as a form of projective identification. Projective identification is the process whereby in a close relationship, as between mother and child, lovers, or therapist and patient, parts of the self may in unconscious fantasy be thought of as being forced into the other person. In R.D. Laing's words, "The one person does not use the other merely as a hook to hang projections on. He/she strives to find in the other, or to induce the other to become, the very embodiment of projection". Feelings which cannot be consciously accessed are defensively projected

into another person in order to evoke the thoughts or feelings projected.

Possible instances of gaslighting by the therapist include:

10. *Making statements, then later denying that she has made those statements.* At one session the therapist stated: “You think you’re smarter than everybody else!” At the following session, the therapist denied ever making that statement. Yet at this session the therapist said: “You think you’re smarter than everybody else” at the point I mentioned that gifted persons have a special need for autonomy.
11. *Praise followed by denigration.* At this session the therapist said at one point, “You are very smart.” Later, the therapist said, “You are a very smart man.” Then later, the therapist turned to denigration, saying, “You think you’re smarter than everybody else!”
12. *Denying feelings.* The therapist consistently denies my feelings relating to alienation, and attempts to instill the view that my feelings are actually rooted in fear and loneliness. It is recognized that there are two characteristics of gaslighting: The abuser (or therapist) wants full control of feelings, thoughts, or actions of the victim (or patient); and the abuser (or therapist) *discreetly* emotionally abuses the victim (or patient) in hostile, abusive, or coercive ways.
13. *Persistent use of questions in therapy rather than interpretation.* The therapist relies a great deal on questions rather than offering feedback in the form of interpretations.

Dorpat describes how persistent questioning by a therapist can constitute gaslighting, or projective identification. “The therapist questioning tends to contribute to the nature and content of the patient’s answers. The transactions in question and answer interactions may be studied from the point of view of interactional processes such as introjection and

projection. Some of the more common contents introjected and projected in question and answer interactions include the following polarities: independence-dependence, power-helplessness, sadism-masochism.” Anderson sees autonomy-vulnerability as polarities as well. See Anderson, J. “Autonomy and Vulnerability Entwined.” Dorpat continues: “In these interactions the questioner assumes the role of the active agent for both parties and projects onto the person he/she questions what the questioner feels to be the less desired quality—for example, dependence, helplessness, masochism. Then the patient introjects the role of the one acted upon and projects the more active role onto the therapist. What we are describing are pathological symbiotic kinds of relations in which emotionally important contents and functions of the more passive partner are projected onto the therapist who, who, in turn, introjects these contents and functions and acts upon them in questioning.”

In one interaction at the session, the therapist asked me a series of questions that promoted feelings of vulnerability in me. The therapist persisted and said, “You are feeling vulnerable, work with me.” It is questionable whether the feelings of vulnerability I experienced in that moment related to actual vulnerability that I fear facing irrespective of the psychotherapy situation or whether I was internalizing the therapist’s own feelings (not consciously accessed) of being vulnerable in relation to me so that her desired outcome was to buttress her ego syntonic view of herself as independent, powerful (and sadistic) in relation to a patient who was forced to play the role of dependent, helpless, vulnerable (and masochistic) passive party. The question is whether, in reality, the therapist was unconsciously attempting to abreact her own feelings of helplessness, dependence, vulnerability (and masochism) in relation to me, a highly autonomous and independent-minded patient. (Note the therapist’s rage reaction – “You think you’re smarter than everybody else!” – when I pointed out that “autonomy” was not necessarily pathological but might be associated with giftedness. I was refusing to

serve as a container for feelings of loneliness and shame, which the therapist apparently associates with her negative view of autonomy.) Was I (an autonomous person) becoming, through gaslighting (projective identification), the very embodiment of the therapist's projection: namely, vulnerable and weak? See Anderson, J. "Autonomy and Vulnerability Entwined."

Therapy Session: August 21, 2018

We are not thinking machines. We are feeling machines that think.

—Antonio Damasio

PATIENT: I want to talk about something about my family. My family background. This goes back to before I was born. You know, I was born six years after my sister. So I formed the idea that my parents looked back on the time before I was born as a kind of idyllic period. That that was the happiest time for them. It was as if that was their Garden of Eden. And when I was born it was as if they were expelled from the garden, from their paradise. So my parents lived in an apartment. It was just the three of them for 6 or 7 years. And whenever they talked about those times, they seemed to have positive thoughts about that time. My parents idealized my sister. She was perfect to them. And I have the sense that when I was born I was a threat to my sister's place in the family. Somehow, perhaps, my presence detracted from my sister. And my parents needed that idealized person. They needed to view my sister as perfect [because it bolstered their own sense of self-esteem]. When I was born there were significant changes for the family. I was a fourth mouth to feed. So I think I might have introduced a financial burden that they didn't have before. My father had a low-paying job. And he could support three people, but maybe with me, that was a financial strain. And then at the very time I was born they moved out of their apartment and bought a house. So that was an additional financial strain. And maybe I was a major reason why they bought a house, I don't know. I know that when I was a kid my parents argued all the time about financial issues, money. That was a major source of tension between my parents. So, yeah, it was as if suddenly I appeared and overnight, things changed for my parents and sister.

* * * *

You know I look to the things I identify with. I see meaning in the things I identify with. I learn about myself by looking at the things I identify with. When I was in college I took a history course about European history [taught by Claire Hirshfield, Ph.D.]. We studied Germany and how Germany in the 1800s was just a collection of separate states, simply principalities. And then in 1871 all these states merged to form the German Empire. And the way my history teacher told it, it was full of drama for me. She talked about how everything was nice and stable in Europe. Everything was peaceful. France was happy because on their eastern border there were these divided, weak German states. And everybody was happy with that situation. And the way my teacher described it – and a kind of a chill went through me the way she described it – suddenly, overnight there sprung up a world-power – the powerful German state – on its Eastern border. And there was a sense of horror all over Europe and especially in France at the sudden emergence of the German Empire. And, you know, I identify with that. I saw myself as arriving on the scene suddenly and I upset the apple cart. I totally changed the balance of power in the family.

THERAPIST: The therapist made a tangential comment. "Nothing happens overnight." She took a rich narrative, full of psychodynamic implications and reduced it to a cliché or truism. She pointed to a factual error in my narrative as if it had importance. "You said it happened overnight. But that was factually wrong. Nothing happens overnight."

The therapist then pursued the issue of factual truth. The therapist said, "Maybe it wasn't idyllic for your parents. Maybe that's your misinterpretation (of the facts). Maybe there were problems even before you were born." Notice how the therapist is taking subjective, or psychic, truth and measuring it by objective standards and saying, in effect, "Maybe you are *factually* wrong. Maybe your parents were not so happy before you were born. Maybe that is simply your (factually distorted) narrative. Let's

reality check your belief." Yes, that is my narrative and my narrative has both factual and psychic components. The therapist seems mired in the factual and the real, as if she sees herself as a fact-checker for *The Washington Post*. If our narratives were all factually accurate, we would all have the same narrative, and we would all be alike; there would be no individuality. But note well: only in cults is the lack of individuality a virtue. It is our personal myths, composed of the symbolic and the imaginary, that make us individuals. As Woody Allen has said, "All people know the same truth. Our lives consist of how we choose to distort it."

A digression:

After the session, I recalled a thought that first occurred to me when I was sixteen years old. My parents had strong racist views; in plain English, they hated black people. My father frequently pointed to the period before blacks started to migrate to Philadelphia, where we lived, after World War II. "This city was so nice before they came. They destroyed the city. They ruin everything." He described what was for him a lost paradise, the Philadelphia of his youth. When I was sixteen I formed the idea that when my father attacked blacks, he might also be disclosing his feelings about me, and plausibly so. It is problematic for a therapist to attempt to undermine a patient's sense of his reality based on a single clinical locution, without an appreciation that that single locution might be supported by a wealth of experiences that the patient cannot immediately recall.

Be that as it may.

I am reminded, *tangentially*, of Melanie Klein's magnificent "Narrative of a Child Analysis" insofar as she is analyzing a boy in England during World

War II. His dreams, art, and play contained multiple *factual* representations about Hitler, bombs, submarines, and the real of the war. She was able to acknowledge this real while also using the material as elements in the symbolic and imaginary, features that were intrinsic to the boy's subjectivity.

The therapist embarked on a line of seeming-CBT inspired comments and questions that centered on the issue of self-blame. What the therapist read into the narrative was that I had the (factually unsupported) belief that I caused problems for my family, that I blamed myself for these problems and that her therapeutic goal was to change my incorrect belief, namely, that I had done something bad, and that I had caused problems for my family.

Significantly, at an earlier session, when I reported that a coworker (Schaar) had said to me, "We're all afraid of you. We're all afraid you're going to buy a gun, bring it in, and shoot everybody," the therapist asked me: "Did that make you feel bad?" Without any basis, the therapist assumed that I had bought into the coworker's disturbed evaluation. At this session, the therapist said, "You said you were to blame for your parents' problems." She exposed the following cognitive distortion in her thinking: "If the outcome is bad, then the cause is bad." Keep in mind, if we look at the Bible, it was God who caused the expulsion of Adam and Eve from Paradise. Perhaps – and I am only saying there are different possible interpretations – perhaps my narrative indicated that as child I saw myself as impactful not as bad: someone who could affect his environment in important ways. Think of my adult heroes – Gandhi (whose activism led to the expulsion of the British from India), Martin Luther King, Jr. and Freud, individuals who disrupted the status quo. *Perhaps as a little boy I discovered (or imagined) that I could have a powerful, disturbing effect on others. Perhaps I experienced as uncanny the sense that the potency of my unconscious destructive impulses seemed verified by my reality.*

The therapist's emphasis on a patient's self-blame is noteworthy. I am reminded of a formula the therapist used at the first session when I reported that my father used to beat me when I was a child. At that first consult the therapist said, "Your father shouldn't have beaten you. You were just a child. You didn't do anything wrong. Children misbehave. It wasn't your fault." In that interpretation the therapist reduced a complex interpersonal dynamic that involved several people in a dysfunctional family system to the simple idea that I had assumed blame for alleged wrongdoing. In the present session the therapist once again applied (or projected) a model involving my "distorted belief," namely, that *I believed* I was to blame for a change in my family circumstances. In the first consult the therapist said, "You did nothing wrong. It wasn't your fault (that your father beat you)." At the present session the therapist said, "You didn't do anything wrong. Your unsupported assumptions about your family's circumstances are the cause of your self-blame. It wasn't your fault."

The therapist's, at times, rigid perceptions occur without regard to the complexity of situations, roles or relationships. Significantly, my psychological test report (which the therapist admitted having read immediately prior to the first consult) offers a different and considerably more complex narrative about my childhood beatings: "Mr. Freedman described a difficult and traumatic childhood. Mr. Freedman's father was physically abusive toward him beginning at an early age. Mr. Freedman's father was also physically abusive towards Mr. Freedman's mother, attempting to strangle her to death at one time during Mr. Freedman's childhood. Mr. Freedman described poor, abusive backgrounds of his mother as well. Mr. Freedman reported that he felt more intense anger at his mother for not protecting him from his father's abuse, as opposed to conscious anger at his father. "The test report highlights issues of trauma, confusion, the witnessing of abuse, intrafamily violence, intergenerational transmission of trauma, anger at mother relating to lack of maternal protection, lack of conscious anger toward father ~ and significantly, no mention of self-blame! Note how the therapist regularly repeats the same

(projected) model. "Patient was aggressed on (or patient believes he was aggressed on), patient struggles with self-blame, and patient needs to be disabused of the belief he did something wrong." That is the therapist's simplistic projection that centers on the issues: **wrongdoing, innocence, blame**. It recurs again and again, in different contexts, and it arises in our therapist-patient relationship as well.

In the therapy relationship, the therapist seems to apply (or project) the same dynamics between her and me, *only with a reversal of roles*. With regard to my letter writing it is as if the therapist were saying, "You *wrongfully* aggress on me with your letters. I am *innocent* of your accusations. It is *wrong* of you to write letters that criticize me. I will not accept your *blame*. I am an outstanding therapist. I did nothing *wrong*." Note the splitting. When I relate anecdotes about my childhood, the therapist depicts me as the innocent "good object" who was wrongly aggressed on and in my adult relationships I am depicted as the bad object who aggresses on innocent parties. Indeed, at another point in the session, the therapist said, "You don't get along with people."

Additionally, the repetition of the same therapy feedback in unrelated contexts creates the impression the therapist is following a (dehumanized) manualized therapy protocol. "If the patient says he was mistreated, tell him the mistreatment was wrong, that the mistreatment should not have occurred, and emphasize the fact that the patient did nothing wrong. The treatment issue here is self-blame. The patient needs to be disabused of his *belief* that he did something wrong. If the patient assumes he was mistreated without evidence, reality test the patient's *belief* and provide alternative viewpoints. The treatment issue here is cognitive distortion" At times the therapist comes across as robotic, *as simply an actor responding to cues by an inner prompter*.

I wrote about these same dynamics in a previous letter about the session on June 19, 2018. In that earlier letter, I observed:

"[The] therapist [seemingly] believes that if other people react negatively to me it is a rational and objective response to my 'bad acts' – and not to any possible subjective bias or irrational animus (counter-transference) by that therapist [or others]. She seems to say that authority figures [or coworkers] will only react to me negatively because I provoke them. That raises questions about the sincerity of a solicitous statement this therapist made at the very first session after I told her that my father used to beat me when I was a boy: 'He shouldn't have done that. You were just a child. Children misbehave. You did nothing wrong.' Why wasn't the therapist thinking at this session, 'You [are] just a vulnerable therapy patient who [uses] writing as a form of self-soothing. . . .' It's as if at this session I was no longer the 'good object' (an innocent child) as I was at the first session. Rather, the therapist transformed me into a "bad object" whose legitimate use of writing as a self-soothing measure aroused a paranoid response from the therapist, who was now the victimized 'good object.' Isn't that counter-transference? *Does the therapist hold simultaneously two opinions about me – as vulnerable child and victimizing adult – which cancel each other out, knowing them to be contradictory and believing both?*" The specific recurring patterns in the therapist's reactions to me over a period of months are noteworthy.

Are there alternative approaches to my clinical report about my family? How about the following, which suggests any number of different angles of interpretation:

HYPOTHETICAL THERAPIST: *You know, sitting here listening to you, I couldn't stop thinking about your extra-terrestrial metaphor from a few sessions back. You talked about the idea that you felt like an extra-terrestrial alien. That*

you had a different identity from everybody else – the humans. As if you had suddenly arrived on planet earth to the horror and amazement of the humans. You seem to be talking today about having those feelings in your family. As if you were an alien. You felt you had an alien identity. That you were fundamentally different from everybody else. That you didn't fit in. That you were treated like an outsider. Weren't these also your feelings in the workplace: that somehow you were different from everybody else, that there was a "lack of fit" between you and the people you worked with?

I am reminded of a story by Kafka, The Metamorphosis. Have you read it? It's about a man who is suddenly transformed into a giant insect – he is an alien in his family. Nabakov had the interesting idea that the story encapsulates the struggles of a creative person in a non-creative environment. Nabakov wrote that the central narrative theme he makes out in the story is the artist's struggle for existence in a society replete with philistines that destroys him step by step. Perhaps you feel both alien and beyond the comprehension of others, but also superior to others, a person with special gifts. Many creative people struggle with these feelings. And, you know, I also sense possible envy and unconscious feelings of triumph in your report. I suspect that at some level you relished the idea of destroying your family's "beautiful world" because it was denied to you. You know there is a psychological theory that the infant both loves and envies the mother's breast: that at some level the infant wants to destroy the mother's breast – precisely because it is good – at those moments the infant feels that the mother has withheld the breast from him. Your family's beautiful world, their Paradise, as you called it, was denied to you and you envied it; you wanted to destroy it.

I'd like to offer a reconstruction that ties together your creativity and your destructive impulses. It may be a regular feature of your mental life that when you envy something and cannot merge with it, you destroy it in fantasy, then recreate an image of that envied object in your mind. What I'm saying is that you envied your parent's paradise, you could not have it, you proceeded to destroy it in fantasy, and you resurrected an image of it in your inner world. I suspect that we

can find residues of former envied objects in your idealized world, your inner Garden of Eden, your own private paradise that you retreat to. But that's only a possible reconstruction.

Be that as it may. You once talked about your grandmother who in fact had an alien status in a legal sense in the United States. That she never adjusted to American society, American culture. And I wonder if there is an issue of intergenerational transmission here. That somehow you have adopted your grandmother's sense of alienness. That that is your family heritage and your legacy. You assumed a kind of scapegoat identity as an outsider who has to live through the experience on a psychological level that your grandmother experienced in her adult life, as if to expiate your grandmother's suffering. Perhaps a latent issue in your narrative is survivor guilt.

Then also, I am struck by the sense of contagion in your report. I have the sense that you see yourself as an invading virus, infecting a healthy person – and radically changing that person's health status overnight, as it were. I remember your saying that your grandmother's husband died in the great flu epidemic. How he was probably a young man, that "suddenly, overnight" your mother's family's circumstances changed radically and unexpectedly with the death of her husband, the breadwinner. And you mentioned that you came down with scarlet fever as a young child, which seems tangentially related. Didn't you say that you came down with scarlet fever at the exact age your mother was when her father died in 1918 – and that it was your mother who negligently fed you spoiled milk?

I was thinking about your comment about the shift in the balance of power in your family when you were born. In intergenerational terms I was thinking about your description of your mother's family. With the death of your mother's father in 1918, there was a remarkable power shift that must have occurred over time. You said that your mother's older sister, over time, took on a maternal role or a caretaking role – you called it role reversal – in which more and more, your aunt

(the child) took on the role of mother to your mother and her own mother. Your grandfather's death was the source of your aunt's power in the family – which must have been a mixed blessing for your aunt: loss of her father, burdensome responsibilities, but also a stepping stone to power. What I am saying is that with your birth there was a power shift in your family. And likewise, when your mother was growing up, there was a power shift in her family as well when her father died. These may be intergenerational issues.

These are just some ideas, Mr. Freedman. We can return to these ideas at a later time if the material warrants. Any thoughts?

THERAPIST'S FAILURE TO IDENTIFY THE TYPICAL DYNAMICS OF FAMILY SCAPEGOATING

In my narrative I described the six-year period in my family before I was born in terms of a three-person system of two parents and an idealized child. I am describing a central triangle characterized by idealization: a family configuration that might plausibly be viewed by family members as a “paradise.” What I described can plausibly be seen as an early precursor of a dysfunctional family system that might come to encompass additional triangles. There can be a certain predictability to the following outcome: where there is a one-child family and that one child is idealized, with the birth of a second child, that second child will be scapegoated.

Dysfunctional families tend to be characterized by splitting and projection in the family system (with prominent idealization and blaming, or scapegoating). This must be so, since dysfunctional families tend to comprise individuals with high levels of individual narcissism in which family members individually show a marked tendency toward black-and-white thinking, that is, dividing the world into all good and all bad. In a

one-child family where that child is idealized (seen as all-good) the stage might be set for a yet-unborn child to be scapegoated (or seen as all bad).

The therapist missed all of the issues relating to the well-known psychodynamics of dysfunctional families implicit in my narrative and, in a misguided application of CBT technique, simply questioned the *factual correctness* of my assertion, namely, that I had the intuitive sense that my parents viewed their early years together as idyllic. In so doing, the therapist ignored the tentative possibility that my parents indeed viewed their early years as idyllic and ignored what that parental belief – combined with their idealization of my sister – implied about the psychodynamics of my family. The pertinent psychodynamic issue is not simply my *belief* that my parents' life was idyllic, but whether, in fact, I am struggling with the recognized consequences of growing up in a narcissistically-disturbed family system that featured the idealization of an older sibling.

The therapist misguidedly redirected the issue from my actual childhood *experiences and feelings* to the factual correctness of my *beliefs* about my family (an intellectualized construct). Keep in mind, in psychodynamic work, a patient's plausible reconstructions based on a patient's creative intuition do not constitute cognitive distortion. Simply because I was describing events that occurred, if at all, before my birth based on my creative intuition does not mean that my description was based on either cognitive distortion or defensive distortion. If we do not think about the many different possible (and plausible) scenarios of a patient's developmental background – and the psychological implications of those different scenarios – we cannot think about different factors that might underlie a patient's psychological struggles and adjustment problems. Of course, if the therapist has a projective agenda, she will not be interested in looking at a variety of interpretations.

Everett and Volgy have described the factors commonly found in dysfunctional families. In some dysfunctional families the most striking feature is that the mechanisms of splitting and projective identification are not displayed simply by an individual but pervade the parent-child subsystem. Splitting occurs when positive and negative feelings and thoughts are separated and experienced by family members in isolation of one another. This splitting distorts the family's perception of reality in such a way as to cause them to experience both internal or external events or issues as either "right" or "wrong," "black" or "white." Such rigidly split perceptions occur without regard to the complexity of situations, roles or relationships. Studies of dysfunctional families identified a similar pattern where within the family system "positive attributes of 'goodness' and negative attributes of 'badness' were separated and reinvested such that each family member appears relatively preambivalent and single-minded in relation to the child." This splitting appears to protect the system from potential feelings of loss and disappointment as well as from the negative affects of anger and hostility.

The projective identification process within a system operates in concert with that of splitting to form rigid role assignments and expectations among specific family members (as in assigning the role of good child to one offspring and bad child to another). In the dysfunctional family, the threat of conflict or aggression in the marriage, which would also threaten the survival of the system, is projected onto a child who "owns" the projection and behaves more aggressively while returning the spousal subsystem to a calmer level. In assessing a clinical family, most family therapists would identify a central triangle, typically between parents and a child, which serves to balance the entire system.

The role of the triangulated child is often defined by either parentification (idealized child) or scapegoating. Everett and Volgy identified in the dysfunctional family predictable patterns of two central triangles and termed these coexisting triangles. It appears that the unique

level of emotional intensity in the dysfunctional family requires multiple central triangles to balance and stabilize the system. They typically take the form of split and projected images of a triangulated “good” child and “bad” child. It appears that the tenuousness of the parental bonding and the continual threat of destructive anger requires two children to perform these specified roles in order to dissipate these threats and to ensure the survival of the system. “Borderline Disorders: Family Assessment and Treatment.” in *Chronic Disorders and the Family*, Walsh, F and Anderson, C.M., eds. (1988).

Everett and Volgy emphasize the role of projection and projective identification in the dysfunctional family that relies on scapegoating. Novick and Kelly found that children who are the objects of projection are subject to intense anxiety and guilt in relation to drive expression. The drives are constantly reinforced by the parental projections, and the development of an autonomous and adaptive defense system is hindered. A brittle superstructure, based on an identification with the primitive superego and defense system of the projecting mother, is created. “Projection and Externalization.” *The Psychoanalytic Study of the Child*, vol. 25: 69-95 (1970).

Brodley found that in dysfunctional families there was extreme individual narcissism, a reliance on projective identification and that family members showed “extreme intensity of relationship.” “On the Dynamics of Narcissism: I. Externalization and Early Ego Development.” *The Psychoanalytic Study of the Child*, vol. 20: 165-193 (1965). If we apply Brodley’s insight to the six-year period before I was born, we can see how, plausibly, my father, my mother, and my sister lived in a triangulated family system characterized by intense bonding of family members and intense idealization and denial of aggression.

The fundamental question is: What did it mean for my psychological development that I might have disrupted such a family system that had maintained its

equilibrium for a six-year period? The therapist failed to consider any of these possible important issues when she applied (or misapplied) a CBT approach that considered only the factual correctness of my narrative.

But there is more than this.

Bell and Vogel found in their study of parental scapegoating, that almost universally the scapegoating of a child occurs in families in which there is a high level of parental discord. In order to reduce tension in the parental subsystem, father and mother will scapegoat one child, that is, they will triangulate that child to diffuse hostility between the parents. Parental scapegoating generally involves the use of a scapegoated child as a diversion from parental discord. The parents end up fighting about the scapegoated child instead of fighting with each other. Vogel, E. F. and Bell, N. W., "The Emotionally Disturbed Child as the Family Scapegoat."

Significantly, in my narrative I stated:

"When I was born there were significant changes for the family. I was a fourth mouth to feed. So I think I might have introduced a financial burden that they didn't have before. My father had a low-paying job. And he could support three people, but maybe with me, that was a financial strain. And then at the very time I was born they moved out of their apartment and bought a house. So that was an additional financial strain. And maybe I was a major reason why they bought a house, I don't know. I know that when I was a kid *my parents argued all the time about financial issues, money. That was a major source of tension between my parents.*"

The factual assertions of my narrative – based partly on creative intuition – are buttressed by well-known and basic theory about family systems. Creative intuition is not a cognitive distortion.

An important issue in assessing the meaning or value of a patient's report is whether that report — which may contain the patient's conjecture — has any explanatory value. Is the patient's narrative consistent with what is already known about the patient or what might plausibly be a factor in the patient's struggles?

My narrative jibes with the expectable developmental background of an adult patient who currently struggles with the aftereffects of blaming, scapegoating, projective identification, harsh criticism, and devaluation — all factors that would be consistent with an introjective patient who has struggled with scapegoating in adult relationships, including the workplace, and who also struggles with unconscious guilt, perfectionism, and self-criticism.

THERAPIST'S FAILURE TO IDENTIFY THE CORE STRUGGLES OF THE IDENTIFIED PATIENT

Another way of looking at my difficulties in my family is to see my problems as those of the so-called Identified Patient. Identified patient is a term used in a clinical setting to describe the person in a dysfunctional family who has been unconsciously selected to act out the family's inner conflicts as a diversion. This person, often a child, is "the split-off carrier of a breakdown in the entire family system," which may be a transgenerational disturbance or trauma.

The dysfunctional family (unconsciously) allocates particular functions to the identified patient in order to have its covert emotional needs met. Projective identification has been singled out as operating at an unconscious level in such families. Role lock — confirming mutual suction into complementary roles, such as victim and abuser — is ensured by the intermeshing of projective identifications of family members. The identified patient is manipulated to play a part, no matter how difficult to

recognize, in the family's phantasy. The identified patient will have no insight into his assigned role, he will have a sense of experiencing strong feelings, and at the same time a belief that their existence is quite adequately justified by the objective situation.

(One wonders whether the therapist's anger at me at times is a response to my refusal to play a role in her internal drama – her unconscious phantasy – and that she unconsciously sees me as failing to meet her covert emotional needs: needs that might include, among other factors, a need for me to validate her idealized self-image as caring, understanding, helpful, comforting and empathic. It is well to keep in mind: Such needs will readily be met by patients with strong dependency needs of their own and will be thwarted by an introjective patient whose concerns center on a search for meaning and identity definition. One might reasonably speculate that the therapist seeks a role lock with her patients – confirming mutual suction into complementary roles, such as “needy and dependent patient” and “empathic therapist.” The intermeshing of projective identifications between needy patients and empathic therapist will ensure therapist satisfaction with anaclitic patients but dissatisfaction with – or even anger toward – introjective/dismissive avoidant patients.)

The term identified patient is also used in the context of organizational management, in circumstances where an individual becomes the carrier of a group problem. Thus, we can see a possible connection between an individual's early problems in a dysfunctional family and his later problems in the workplace.

The psychodynamics of the identified patient comprise an unconscious pattern of behavior whereby an excess of painful feelings in a family lead to one member being identified as the cause of all the difficulties – a scapegoating of the identified patient. The identified patient both conceals and reveals a family's secret agendas.

Thinking about the dynamics of the identified patient as representing unconscious agendas and unconscious communication patterns within a family nexus gives added weight to the view that the therapist's emphasis on my *beliefs* about my family is misguided. The issue is not my conscious beliefs or *factual assertions* about my family, but how I might have been emotionally affected by exposure to disturbed *experiences* in a dysfunctional family system in which I was forced to assume – through projective identification or other covert mechanisms – the role of family scapegoat. In sum, the issue is not my *beliefs* – which can be addressed with a CBT approach – but my lived *experiences* (and associated unconscious feelings) and how I have unconsciously registered those experiences: issues that lie beyond the ministrations of CBT technique. *Once again, we are not thinking machines. We are feeling machines that think.*

The following is a list of the typical problems found in the identified patient that I appear to struggle with:

Lack the ability to be playful, or childlike, and may “grow up too fast.” (We can see a possible connection to my social anhedonia—my inability to participate in many activities others find pleasurable);

Have moderate to severe mental health issues, including possible depression, anxiety, and suicidal thoughts (I attempted suicide at age 23);

Become addicted to smoking, alcohol, or drugs, especially if parents or friends have done the same. (I used to be a heavy cigarette smoker, and had a drinking problem when I was in my forties);

Be an easy victim of bullying or harassment. (I was a victim of severe

workplace harassment in two places of employment. Note how the therapist invidiously depicted my workplace difficulties; “You don’t get along with people,” which was itself a form of scapegoating by the therapist);

Be in denial regarding the severity of the family’s situation. (Not how my family problems may be even more serious than I depict them. The therapist minimizes problems in my family with statements such as, “I wouldn’t say your mother was negligent,” “Maybe your grandfather was not exploitive,” “Maybe your problem with your brother-in-law is that he interfered with your attachment to your sister” (and not that he was abusive));

Have mixed feelings of love–hate towards certain family members;

Have difficulty forming healthy relationships within their peer group;

Spend an inordinate amount of time alone watching television, playing video games, surfing the Internet, listening to music, and other activities which lack in-person social interaction;

Feel angry, anxious, depressed, isolated from others, or unlovable;

Distrust others or even have paranoia (my paranoia score on the MMPI was statistically significant);

Struggle academically at school or academic performance declines unexpectedly. (I had serious academic problems in high school);

Have low self-esteem or a poor self-image with difficulty expressing emotions. (Therapists consistently talk about my inability to talk about my feelings);

Rebel against parental authority. (Note how my conflicts with the therapist might be rooted in early scapegoating in my family);

Think only of themselves to make up the difference of their childhoods (as they are still learning the balance of self-love.);

Live a reclusive lifestyle without any spouse, partner, children, or friends;

Have auto-destructive or potentially self-damaging behaviors;

Strive (as young adults) to live far away from particular family members or the family as a whole, possibly spending much more time with extended family. (I am originally from Philadelphia, but in my twenties I moved to Spokane, Washington and later moved to Washington, DC. Interestingly, my niece, originally from New Jersey, moved to Hawaii, then Idaho, then Arizona. She rarely communicates with her mother (my sister) – suggesting a recurring pattern in the extended family dynamic.).

The therapist consistently fails to address the source of these problems, namely, my *experiences* in a disturbed family environment, and misguidedly focuses on what she terms as flaws in my *thinking*. Once again, it is not my *thinking* that is disturbed, it is that my *experiences* were full of unbearable affect, a situation that would give rise to typical defenses and structures. Abusive experiences are not simply recorded in memory as thoughts; they are unconsciously recorded in the ego as defenses and maladaptive structures.

A Holocaust survivor is not struggling with flaws in his *beliefs* about how he was perceived by the German government; he struggles with the effects of victimization. “The Nazis blamed your people for Germany’s loss in World War I and that your people caused the German hyperinflation in the early 1920s. *But that is factually incorrect.* You were not the cause of Germany’s problems. You did nothing wrong. The Germans should not have imprisoned you in a camp. It was wrong of them to do that. You are not to blame for Germany’s problems.” Yes, but what about the years of abuse in Nazi Germany – and the consequences of that abuse? The Holocaust survivor is not struggling with his *beliefs* about false accusations by an abusive government; he is struggling with the *experience* of abuse by an abusive government. The hypothetical therapist in this example denies the specific psychological problems of an individual with the identity “Jew” who was victimized by exploitative anti-Semites.

A victim of racism is not struggling with flaws in his *beliefs* about how he is perceived by non-blacks: “They blame you for being lazy and shiftless. But they are wrong. You’re not lazy and shiftless. *It is factually incorrect of an employer to say that.* It was wrong of them to say that. You did nothing wrong. Your problem is that you buy into stereotypes. The problem is your beliefs. Just don’t believe them when they say bad things about you. And if an employer refuses to hire you, just tell yourself, ‘I am not lazy and shiftless.’ Changing your flawed beliefs will change the way you feel about yourself.” The hypothetical therapist in this example denies the specific psychological problems of an individual with the identity “African-American” who was victimized by exploitative racists.

It is problematic for a therapist to tell a patient: “Let me show you how your abusive life experiences can be seen in a different light. The problem is not your experiences, the problem is your flawed beliefs and perceptions.” At this therapy session the therapist denied the specific psychological problems of a patient with the identity “scapegoat” or

“identified patient” who was victimized by narcissistically-disturbed relatives in a dysfunctional family who sought to exploit the patient to serve their own psychological agenda.

There are indications of anal sadism in the therapist’s approach. The anal sadist denies the identity of the victim in order to exercise power over the victim (or exploit the victim) and as a way of minimizing his own feelings of guilt. In each of the hypothetical examples above, the “therapist” denies the specific psychological problems of an individual with a specific identity who has been victimized by those who seek to exercise power over him — precisely *because* of that specific identity — and exploit him in furtherance of their own warped agenda.

THERAPIST'S FAILURE TO IDENTIFY EVIDENCE OF POSSIBLE INTERGENERATIONAL TRANSMISSION OF TRAUMA

The dysfunctional family can be characterized as the product of intergenerational enmeshment across at least three generations. In such families the differentiation of subsystems and their internal boundaries are diffuse. The parents display continuing high loyalties to their respective families of origin with the resultant lack of personal individuation and separation. The emotional core of the system is a collusively-held myth that loss and separation are too painful for the system to tolerate and the expression of anger is dangerous and threatening to the survival of the system and its members. Everett and Volgy.

I want to focus on speculative ideas about a significant loss that occurred in my extended family. My mother's father died when she was three years old; he succumbed in the great influenza pandemic of 1918. In addition to emotional loss, my mother's father's death resulted in serious problems

of adjustment for her own mother (my grandmother), a Polish immigrant who failed to assimilate into American culture. My mother's father's death also led to role reversal in her family, with my mother's two-year older sister (my mother's only sibling) assuming over coming years a caretaking role for my grandmother and my mother. In an important way, my mother's older sister assumed the role of her deceased father as family caretaker. My mother's family struggled with severe material deprivation in the years before social welfare programs (the 1920s) and moved from a coal mining community in West Virginia, to New York City, finally settling in Philadelphia.

Previously, I had reported the following facts to the therapist: *My grandmother was a paranoid and dysfunctional individual who was intensely and obsessively anti-Semitic. She emigrated from Poland at age 18 but never learned more than rudimentary English. In my mother's family of origin there was severe role reversal, with my mother's older sister having to assume a parental role in early childhood to compensate for my grandmother's inadequacy. My mother's family of origin struggled with extreme poverty in the days before social welfare programs: my mother reported that there were many days when there was nothing to eat but rice boiled in milk. (Note the issue of "boiled milk" – my mother's act of feeding me spoiled boiled milk at age 3 – the same age she was when her father died – caused my scarlet fever, an infectious disease.)*

The following portion of this session's narrative is pertinent to childhood material deprivation: "I was a fourth mouth to feed. So I think I might have introduced a financial burden that they didn't have before. My father had a low-paying job. And he could support three people, but maybe with me, that was a financial strain. And then at the very time I was born they moved out of their apartment and bought a house. So that was an additional financial strain."

From a CBT perspective, one might question the factual accuracy of my report; perhaps, there was no material deprivation in my childhood. But from the perspective of intergenerational transmission one cannot rule out the possibility that my report was rooted in the fact that I was *immersed in my mother's childhood reality*. In this one example we can see that haphazardly appraising a patient's narrative on the basis of *factual accuracy* may only distort – sometimes in significant ways – the patient's psychological reality and the nature of his struggles. Whether a patient's narrative is *factually accurate* is utterly irrelevant to many issues of psychological importance. By analogy, correcting a person's Rorschach responses – “You say that looks like a horse, but might it not also be seen as an antelope or a sheep?” – ignores the individual's psychic reality, a determinant of individuality. I am struggling with a perverse (unconscious) psychic reality, not a flawed perception of a consciously-perceived reality.

The literature confirms the serious emotional effects of loss and trauma (and material deprivation) across generations. Fonagy references a patient who *appeared to live in the reality of the past of her father*, a Holocaust survivor. The patient is noted to have retreated into a narcissistic grandiosity that could withstand the harsh conditions that her father had survived. What is at work in second-generation victims is not covered by the concept of identification; that it is tantamount to *the patient's immersion in another reality*. The mechanism of “transposition” resurrects the dead objects whom the caregiver (the survivor) cannot adequately mourn. The objects are re-created in the mind of the second-generation survivor at the cost of extinguishing the psychic center of his own life. Fonagy, P. “The transgenerational transmission of holocaust trauma. Lessons learned from the analysis of an adolescent with obsessive-compulsive disorder.”

To what extent am I living in the reality of my mother's childhood – a

childhood characterized by emotional loss, material deprivation and abuse? To what extent are some of my personality traits adaptive to my mother's childhood rather than mine? (It has been found that children of parents who struggle with unresolved loss may find themselves identifying with parental character traits produced by that experience.) To what extent have I recreated in my internal object world my mother's dead father?

What we are talking about is the transposition of trauma across generations. Focusing on the *factual assertions* in the narrative of a patient struggling with "borrowed trauma" is a dubious exercise, to say the least.

It is also useful to think about the concept of the so-called "replacement child." A replacement child in a literal sense is one conceived to take the place of a deceased sibling. Anisfeld believes the concept may be extended to many other situations in which a child is put in the place of someone else in the family system. The replacement child fills the void in the lives not only of individual parents but of the family as a whole. Cf. Anisfeld. Was I assigned by my mother the role of replacement child for my mother's deceased father, whom she lost at age three? Was my mother's possible replacement child fantasy unconsciously shared by my aunt and my grandmother as a collusively-held myth? Volkan introduced the concept of deposit representations, a form of projective identification. In Volkan's words, "This concept refers to a type of intergenerational transmission where a parent or other important individuals (such as grandmother or aunt) deposits into a child's developing self-representation a preformed self- or object representation that comes from the older individual's mind." A precondition for the development of the intrapsychic structures characteristic of the replacement child, according to Volkan, is "the permeability between the psychic boundaries of the very young child and his mother, which allows the 'various psychic contents' to pass from one to the other's self-representation." Anisfeld, L. "The

replacement child. Variations on a theme in history and psychoanalysis.”

THERAPIST'S FAILURE TO LINK FAMILY SCAPEGOATING WITH SCAPEGOATING IN THE WORKPLACE / THERAPIST'S ACT OF SCAPEGOATING THE PATIENT BY SAYING: "YOU DON'T GET ALONG WITH PEOPLE"

The therapist said, “You don't get along with people.” Indeed, I have had severe problems with coworkers in my last two places of employment. But the therapist failed to link my adult interpersonal problems in the workplace to my scapegoat role as a child in a dysfunctional family.

Individual history can prime an individual to receive a certain type of group projection. Individuals, for example, who have been designated as black sheep in families may be predisposed to become scapegoats in groups. Hazel, C. *Imaginary Groups*.

There is a notable similarity between the psychodynamics of dysfunctional families and dysfunctional groups. As noted above, the term identified patient is also used in the context of organizational management, in circumstances where an individual becomes the carrier of a group problem, such as, in the workplace.

The dysfunctional family is characterized by shared splitting and projective mechanisms by family members. Everett and Volgy. It will be noted that splitting and projection are the core features of paranoid schizoid anxiety. It is as though the members of dysfunctional families unconsciously place part of the contents of their deep inner lives outside themselves and pool these parts in the emotional life of the family, depositing bad internal objects and impulses in a scapegoat. In the

dysfunctional family one child may be scapegoated to preserve harmony between parents. Bell and Vogel.

Likewise, many observers have noted that there is a strikingly close correspondence between certain group phenomena and those processes in the individual that represent what Melanie Klein has called the psychotic level of human development. Bion has suggested that the emotional life of the group is only understandable in terms of processes at this very primitive level. To a significant degree, institutions and groups are used by their individual members to reinforce mechanisms of defense against anxiety, and in particular against recurrence of the early paranoid anxieties (defended against by splitting and projection) and depressive anxieties first described by Klein. It is as though the members of groups unconsciously place part of the contents of their deep inner lives outside themselves and pool these parts in the emotional life of the group.

Jaques, E. "On the Dynamics of Social Structure – A Contribution to the Psychoanalytical Study of Social Phenomena Deriving from the Views of Melanie Klein."

The phenomenon of scapegoating is one example of a social mechanism of defense against paranoid anxieties in which group members put bad internal objects and impulses into particular members of a group or institution, who are unconsciously selected, or themselves choose to introject bad objects and impulses and either absorb them or deflect them (possibly because of early developmental priming in a dysfunctional family, *see Hazel*). In the group, everyone's bad objects and impulses may be deposited within the scapegoat, who is regarded by common consent as the source of trouble. By this mechanism group members can find relief from their own internal persecution. And the members of the group or institution can thereby more readily idealize and identify with "good" figures. See Jaques.

In regressed groups, members fear both differentiation (individuality) by other group members and potential group hostility if others openly express their individuality. Diamond, M.A. and Allcorn, S. "The Psychodynamics of Regression in Work Groups." Kernberg observes that regressed group members will attack individuals who retain their thinking, their individuality, and their rationality. See *Ideology, Conflict, and Leadership in Groups and Organizations*. Note how the therapist's drive toward *deindividuation* (which might be termed anal sadism), will provoke conflict with an autonomous and creative patient who places a premium on *individuality* in the same way an autonomous and creative employee will tend to have difficulties with regressed and dedifferentiated employees in the workplace. In a regressed group that emphasizes *deindividuation*, the autonomous individual might not "get along with people."

In my last two places of employment I appeared to be the target of workplace mobbing. Mobbing, as a sociological term, means bullying of an individual by a group, in any context, such as a family, peer group, school, workplace, neighborhood, community, or online. When it occurs as emotional abuse in the workplace, such as "ganging up" by co-workers, subordinates or superiors, it has the purpose of forcing someone out of the workplace through rumor, innuendo, intimidation, humiliation, discrediting, and isolation.

Some research indicates that mobbing is typically found in work environments that have poorly organized production or working methods and incapable or *inattentive management* and that mobbing victims are usually "exceptional individuals who demonstrated intelligence, competence, *creativity*, integrity, accomplishment and dedication." Davenport, N.Z., Schwartz, R.D. & Elliott, G.P., *Mobbing: Emotional Abuse in the American Workplace*. In one job performance evaluation, my

supervisor described me as being “as close to the perfect employee as it is possible to get.”

When the therapist said, “You don't get along with people,” we may ask precisely who were the people with whom I had difficulty at my last place of employment. What was their identity? We can answer that question as follows. I “didn't get along with people” in an organization where my supervisor (Robertson) was a court-adjudicated racist, the law firm managing partner (Hoffman) was cited by the D.C. Court of Appeals as having lax management practices (“*inattentive management*”), *see In Re Morrell*, 684 A.2d 361 (1996), the firm's hiring partner (Race) likely committed perjury, and a coworker (Schaar) who said I might be homicidal was later terminated for gross misconduct. When the therapist said, “You don't get along with people,” she denuded those people of identity (in the therapist's description, those “people” became a *dedifferentiated mass*) – an anal sadistic procedure – and invidiously created a false impression of me, as if she were saying, “*It was your fault you didn't get along with people.*”

Return at this moment to what the therapist said at the opening of the session: “The therapist embarked on a line of seeming-CBT inspired comments and questions that centered on the issue of *self-blame*. What the therapist read into the narrative was that I had the (factually unsupported) belief that I *caused problems* for my family, that I *blamed myself for these problems* and that her therapeutic goal was to change my incorrect belief, namely, that I had done something bad, and that I had *caused problems* for my family.” . . . “[T]he therapist hold[s] simultaneously two opinions about me – as vulnerable child and victimizing adult – which cancel each other out, knowing them to be contradictory and believing both[.]”

I repeat: Note how the therapist's drive toward deindividuation (which might be termed *anal sadism*), will provoke conflict with an autonomous and creative patient who places a premium on individuality in the same way an autonomous and creative employee will tend to have difficulties with regressed and

dedifferentiated employees in the workplace. In a regressed group that emphasizes deindividuation, the autonomous individual might not “get along with people.”

THERAPIST'S APPARENT INABILITY TO WORK WITH A CREATIVELY-GIFTED PATIENT

The therapist chastised me about my resistance in therapy. She indicated that she was put off by the rigidity of my thinking and my failure to accept alternative points of view. I have formed the belief that most of the therapist's other patients are much more open to suggestion than I am and that, at a personal level, are far more disposed to form a collaborative alliance with her.

Several times I have asked a question of my therapist. And consistently she will not answer me. I have asked, "You know, you seem like a very likable person. I don't know anything about your relations with people in your private life or in your therapy work — I don't know anything about your other patients — but I would imagine you are well-liked by people. I imagine you have a lot of friends and warm social relations. I imagine that the vast majority of your patients like you, that they look forward to talking to you, and that they see you as a source of comfort and strength. I think it must say something about me that I don't have that reaction. I have many negative feelings about you. I think that has to be significant. Why am I so resistant to you and your personality? I have to believe that my reaction to you says very important things about me."

As I say, the therapist will not address that question. Maybe she thinks I am simply a crackpot, and she doesn't want to insult me. But I keep thinking, "What is my reference group? Who is the class of persons who resemble me? What is that class of patients who might be unusually

resistant to her feedback and who might have negative feelings about the therapist's directive therapy technique? In the language of a metaphor I have used in the past, "Am I just a deviant fish or am I dolphin who can be profiled?"

I have thought of a possible reference group that clarifies difficulties I have with the therapist that center on a patient's autonomy and independent cognition. *Might that reference group consist of that class of persons who take on the role of lone holdout on a jury?* You have to wonder about a person who will steadfastly refuse to go along with eleven other jurors, despite what must be, at times, excruciating pressure to conform. And also, from an intellectual standpoint, who is the one person in eleven who looks at a set of facts and reaches a conclusion different from that of the overwhelming majority?

I found that there is a body of research on the psychology of the lone holdout.

One study states: "Studies have been conducted to evaluate whether and how holdouts (or a certain type of resistant patient) differ from the majority (the therapist) and from dissenters who eventually go along with the majority. As noted earlier, some have suggested that the lone holdout is a crackpot or a flake (a "deviant fish," as it were), but research contradicts this conjecture. In fact, some research suggests that holdouts are neither irrational nor eccentric (in fact they say dolphins are very smart!), and they do not ask unreasonable or illogical questions." The study also states: "Those who make their livings by "*thinking outside the box*" or by *virtue of their personal creativity* (e.g., artists, musicians, researchers) seem more likely than others to be self-referential and less likely to bow to the pressure of the majority. These are individuals (like creatively-gifted patients) who respect their own views to an unusual

extent because their livelihoods depend on their creativity in a more singular way." Blackman, J. and Dillon, M.K., *The Lone Juror Holdout*. Is it perhaps that my therapist has little experience working with creatively-gifted patients and that my creative personality is a major source of my resistance in therapy? May we say that a mix of cognitive and personality issues centering on creativity dispose me to resistance in therapy?

Let us review the recognized personality characteristics of creative persons. See Raudsepp, E. "Profile of the Creative Individual." We can see how most of the following traits might impair the ability of a creative patient to form a therapy alliance with a directive therapist:

- * He is more observant and perceptive, and he puts a high value on independent "true-to-himself" perception. He perceives things the way other people do but also the way others do not.
- * He is more independent in his judgments, and his self-directed behavior is determined by his own set of values and ethical standards.
- * He balks at group standards, pressures to conform and external controls. *He asserts his independence without being hostile or aggressive, and he speaks his mind without being domineering.* If need be, he is flexible enough to simulate the prevailing norms of cultural and organizational behavior.
- * He dislikes policing himself and others; he does not like to be bossed around. *He can readily entertain impulses and ideas that are commonly considered taboo;* he has a spirit of adventure.
- * He is highly individualistic and non-conventional in a constructive manner. Psychologist Donald W. MacKinnon puts it this way: "Although

independent in thought and action, the creative person does not make a show of his independence; he does not do the off-beat thing narcissistically, that is, to call attention to himself. ... He is not a deliberate nonconformist but a genuinely independent and autonomous person."

* He has wide interests and multiple potentials—sufficient to succeed in several careers.

* He is constitutionally more energetic and vigorous and, when creatively engaged, can marshal an exceptional fund of psychic and physical energy.

* He is less anxious and possesses greater stability.

* His complex personality is, simultaneously, more primitive and more cultured, more destructive and more constructive, *crazier and saner*. He has a greater appreciation and acceptance of the nonrational elements in himself and others.

* He is willing to entertain and express personal impulses, and pays more attention to his "inner voices." He likes to see himself as being different from others, and he has greater self-acceptance.

* He has strong aesthetic drive and sensitivity, and a greater interest in the artistic and aesthetic fields. He prefers to order the forms of his own experience aesthetically, and the solutions at which he arrives must not only be creative, but elegant.

* Truth for him has to be clothed in beauty to make it attractive.

* He searches for philosophical meanings and theoretical constructs and

tends to prefer working with ideas, in contradistinction to the less creative who prefer to deal with the practical and concrete.

* He has a greater need for variety and is almost insatiable for intellectual ordering and comprehension.

* He places great value on humor of the philosophical sort and possesses a unique sense of humor.

* He regards authority as arbitrary, contingent on continued and demonstrable superiority. When evaluating communications [such as those of a therapist or a trial expert], he separates source from content, judges and reaches conclusions based on the information itself, rather than whether the information source was an "authority" or an "expert."

The Dream of Schubert's Final Piano Sonata

Franz Schubert wrote the Piano Sonata No. 21 in B flat major in the last year of his life, when he probably knew he was dying. It was his final piano sonata. The sonata opens with a serene theme that is interrupted by a menacing trill in a low register. Commentators have compared these opening measures with a pastoral setting whose calmness is interrupted by a meteorological event, namely, a roll of distant thunder. Then too, it has been said that from wherever the theme may come, the trill comes from somewhere else, the trill evinces a “separate identity from the surrounding music,” an identity that is bound up with its introducing a “foreign tonal region.” Musicologists have interpreted the sonata’s tonal peregrinations and final tonal resolution in metaphysical terms, namely, as Schubert’s return, or “homecoming,” to the tonal dominant key. In the end, Schubert “returns home” to the key of B flat major after “wanderings of a long and dramatic development” into distant or “foreign” keys: “a weary return to the beginning of the journey.” Horton, J., *Schubert*. About a year ago I downloaded a recording of the sonata on my iPod, a version performed by the great Chilean pianist, Claudio Arrau. I had seen Arrau perform the Brahms First Piano Concerto in person at the Robin Hood Dell (in a program that included the Beethoven Seventh Symphony) in the summer of about the year 1972, when I would have been 18 years old.

Dream of Schubert's Final Piano Sonata

On the evening of May 21, 2018 I had the following dream: I am watching the movie Dr. Zhivago on television. I am experiencing feelings of confusion because the movie seems to include scenes I have never seen before. I think: “How can this be? I have seen this movie so many times; how can it be that I can’t remember these scenes? Did I forget seeing these scenes, or is this a different version of the movie?” I keep hearing Schubert’s final piano sonata. I am entranced by the music. I am overcome with feelings of wistfulness and nostalgia – commingled with the aforementioned feelings of confusion.

The following are my associations to the dream:

1. In the hours before the dream, I wrote a blog post about my impoverished sense of identity. I have the sense that I have no access to my feelings and important mental states, and can only talk about analogous things I read about with which I identify. It's as if the texts I read and identify with are a mirror reflection of my inner mental states: photographic images of my inner self. The text of the blog post is as follows:

On Mirrors and Intellectualization

Imagine the following fanciful image: A man is invisible to himself. He cannot see himself. When he turns his head down toward his body he sees nothing. People say to him: "Describe your appearance. What do you think you look like?" He answers: "I have no idea what I look like. I have never seen myself. I am invisible." One day he passes by a mirror and sees his reflection for the first time. He gets an idea of what he looks like. Now when people say, "Talk about your physical appearance," he describes the reflected image he saw in the mirror. He still can't see himself. He can only describe the reflected image. Psychologically I am invisible to myself. I can't talk about my feelings. I can talk about my thoughts and notions I have about myself, but I can't talk about how I feel or what motivates my behavior. I read things that I identify with – novels, biographies, history, any text. I talk about these texts with my therapists. They say I intellectualize. I need to talk in my own words and describe my feelings. But I am invisible to myself. I can only see my reflected image in the texts that I read with which I identify. I read about Freud and I can talk about aspects of Freud that I identify with.

Some therapists think I am grandiose: that I am trying to show off. "He reads these psychoanalytic journals and tries to impress me with his brilliance." My behavior is narcissistic – but not grandiose. It's as if I am narcissistic in a Kohut

sense but not in a Kernberg sense. There are defects in my sense of self, gaps in my self-awareness. My only access to myself is in my readings and what I identify with. I used to bring books to Dr. Palombo all the time and read passages to him. If he had been a Kohutian he might have had an insight: "It's as if this patient is bringing his own mirror into the consult with him. He is presenting me week after week with his reflected image in the mirror. But his real self is obscure to him." I wonder if this is a trauma issue. Is this an expression of dissociation – dissociation rooted in trauma or abuse?

2. In the past few days I had been thinking of my law professor, Claudio Grossman, an individual I admired a great deal and with whom I identified. Grossman was originally from Chile, like the pianist Claudio Arrau. A few days ago I wrote a blog post about Grossman's complex background, and issues of his personal identity. Grossman was an immigrant, someone who had left his homeland: an alien in a strange land.

3. In high school I had a French teacher named Linda Schubert Miller. She got married in the spring of 1968, when I was in the ninth grade and I always thought of her as "Miss Schubert." A few days ago I posted an image of Miller from a 1969 high school yearbook on my sister's Facebook page. I asked my sister, "Does it look like her?" My sister replied, "Yes, it does." About 10 years ago, my sister and Miller were neighbors in Cherry Hill, NJ. My sister knew Miller. Miller's husband was a musician.

4. In May 1980 I lived in Spokane, Washington, attending my first year of law school. On Sunday May 18, 1980, at 8:32 AM, Mount St. Helens erupted in Washington, State. Spokane was downwind from the volcanic ash and an emergency situation arose in Spokane. I wasn't listening to the radio that morning and I knew nothing about the eruption. I took a leisurely walk downtown that afternoon. It was a still and sunny spring afternoon; a huge, grayish-green cloud slowly approached the city. It

looked like a storm cloud, but there was no thunder. I thought, “Wow, I never saw anything like that before! That’s amazing!” The movie, *Dr. Zhivago* was playing at a theater downtown and I decided to see it – for perhaps the seventh time in my life. That was a misadventure. When I got out of the theater at about 5:00 PM, Spokane was engulfed in volcanic ash – microscopic particles that created a dense fog. It looked like the dead of night. There was extremely limited visibility. It was worse than a blizzard or a bad fog. I walked down the street. I thought: *How am I going to get home?* (Think of that as a symbolic thought: “How am I going to get home?”) An anonymous driver was kind enough to pick me up and drive me home. At the present moment, the state of Hawaii is coping with a volcano emergency. My mother died in January 1980. Psychoanalytically, perhaps a volcano is symbolic of an orgasm. According to Freud and others sex is the polar opposite of death.

5. In the year 2012 I had a dream about Laurence C. Sack, M.D., a psychiatrist I consulted in 1991; he had died in 2003. I admired Dr. Sack a great deal. He was a brilliant man. That dream concerned wistful feelings I had about Dr. Sack’s lost youth and his growing old. In the dream I imagined that Dr. Sack was an immigrant: someone who had left the United States to live in Israel. The dream seemed to be triggered by a photograph I had seen earlier in the day of the composer, Johannes Brahms in his youth.

6. My grandmother died in September 1972, when I was 18 years old. In about the year 2007 I saw an episode of the TV series *Six Feet Under*. A young man asks a young female photographer friend to take his photograph nude. She mentions that she is 18 years old and he replies: “What you don’t know when you’re 18 is that you’ll be 18 for the rest of your life.” I think of that line often. “What you don’t know when you’re 18 is that you’ll be 18 for the rest of your life.” Incidentally, my grandmother emigrated from Poland to the United States in 1910 at age 18. My grandmother was an immigrant who left her homeland; she never

acculturated to the United States—she was forever an alien intruder in a strange land. Were there times when my grandmother wanted to return home? Did she think: “*How am I going to get home?*” I lost my grandmother when I was 18, the same age my grandmother was when she lost her entire family in 1910 upon moving to the United States.

There is a line from the opening of the movie *Dr. Zhivago*. Zhivago’s half-bother, Evgraf is talking to Zhivago’s daughter. “*You see, he lost his mother at about the same age you were when your mother lost you. And, in the same part of the world.*”

Did the dream-work combine recollections of viewing the movie, *Dr. Zhivago* on the afternoon of May 18, 1980 with unconscious thoughts about my immigrant Polish grandmother, specifically the death in 1918 of her husband, my maternal grandfather, Stanley?

The subject matter of the movie *Dr. Zhivago* concerns the Russian Revolution. *In reviewing my associations to the dream I thought: How was Poland affected by the Russian Revolution?* I discovered something striking about Soviet-Polish relations in that time period. The Soviet Union under Lenin went to war with Poland in February 1919. Months after my maternal grandfather died, in 1918, Poland became engulfed in political turmoil — which might relate to possible anxieties my grandmother had about her homeland, and possibly returning to Poland after her husband’s death. *How was she going to get home?*

Were these possible anxieties encoded in my unconscious through a process of intergenerational transmission? One wonders.

Attachment theory research raises tantalizing questions about the significance of my mother’s loss of her father at age 3 (in the great flu epidemic of 1918) – leaving my mother, her two-year older sister (age 5), and mother (my grandmother, age 26) in dire poverty – as well as my

grandmother's loss of her entire family, earlier, in 1910, at age 18, upon emigrating to the United States.

Research findings indicate that loss can undergo intergenerational transmission. "[There is] preliminary evidence that a mother's own attachment experience in childhood may influence the development of reward and affiliation circuits in the brain that promote contingent and sensitive responses to her own infant's cues. That is, a mother's attachment experiences from her own childhood may shape neural circuits which influence how she perceives and responds to her infant's cues one generation later." Shah, P.E.; Fonagy, P.; and Strathearn, L. "Is Attachment Transmitted Across Generations? The Plot Thickens," *Clin Child Psychol Psychiatry*, 2010 Jul; 15(3): 329-345 (July 2010). Additional attachment-theory models indicate the possibility that transmission of specific traumatic ideas across generations may be mediated by a vulnerability to dissociative states established in the infant by frightened or frightening caregiving, which, in its turn, is trauma-related. Disorganized attachment behavior in infancy may indicate an absence of self-organization, or a dissociative core self. This leaves the child susceptible to the internalization of sets of trauma-related ideation from the attachment figure, which remain unintegrated in the self-structure and cannot be reflected on or thought about. The disturbing effect of these ideas may be relatively easily addressed by a psychotherapeutic treatment approach that emphasizes the importance of mentalization and the role of playful engagement with feelings and beliefs rather than a classical insight-oriented, interpretive approach. Fonagy, P. "The transgenerational transmission of holocaust trauma." *Attachment & Human Development*, 1(1): 92-114 (April 1999).

From my birth till about age six months my mother shared maternal caretaking with her mother, my grandmother. My mother said that it was frequently my grandmother who fed and changed me. My grandmother,

mother and I lived temporarily in my grandmother's house. What was the nature of my possible early psychological attachment to my grandmother? When my mother moved out of my grandmother's house when I was six months old, thereby ending my close contact with my grandmother, did I experience attendant loss and mourning? See Bowlby, J. "Grief and Mourning in Infancy and Early Childhood."

Issues of personal identity and *narcissistic mirroring* are raised by my association to the following dialogue from an episode of the TV series, *Six Feet Under*.

BILLY: Come on in. All right, let me show you. [Billy shows Claire the camera on a tripod.] You can put your purse down if you like. Here it is. This is your focus, and this is your zoom. That's pretty much it. So here you go. You'll get a feel for it.

CLAIRe: Okay, what do you want me to do?

BILLY [pulls off his robe with his naked back to Claire]: Just, you know, follow your instincts. Relax. Don't think about yourself at all. I know that's impossible for a 17-year-old.

CLAIRe: Eighteen.

BILLY [his back to Claire:] What you don't know is you're going to be 18 for the rest of your life. I've tried to do self-portraits before but they always turn out so contrived, like I'm trying to be some version of myself. So f---g juvenile. And I really want to see it, you know? [referring to a scar on his back.] I want to. I need to see what I've done. *And I think it really is impossible for somebody to see themselves. You need someone else's eyes.* I need somebody else to see me. Somebody who isn't Brenda [Billy's sister]. She sees things a little too darkly. I mean, I don't need any help going there.

Besides, I've looked through her eyes enough for one lifetime, you know.
What are you seeing?

CLAIRE: I'm on your scar, really close up. [Billy has a scar on his back from a wound he inflicted on himself during a psychotic manic attack.]

BILLY: What does it look like?

CLAIRE: Like the surface of the moon.

BILLY: That's good. *That's the thing about Narcissus. It's not that he's so f---g in love with himself, because he isn't at all. F---g hates himself. It's that without that reflection looking back at him he doesn't exist.* [Billy cries.]

CLAIRE: Billy, are you okay?

BILLY: Yeah. Don't be freaked out. This is good. This is exactly what I needed to happen. I'm f---g crying. Oh, God, I'm sorry, this is intense. [Billy turns around, exposing himself to Claire. She is extremely embarrassed. She averts her gaze and walks out.]

BILLY: You can go.

Think of the line, "It's that without that reflection looking back at him he doesn't exist." May we paraphrase and say, "It's that without my books (my reflected image), I don't exist?"

7. Excerpt from my book *Significant Moments* (May 22 is Wagner's birthday):

Three nights before his death, . . .

Martin Gregor-Dellin, *Richard Wagner: His Life, His Work, His*

Century.

Almost poetically, . . .

Peter Gay, *Freud: A Life for Our Time.*

. . . he dreamed of meeting . . .

Martin Gregor-Dellin, *Richard Wagner: His Life, His Work, His Century.*

. . . his mother . . .

Richard Wagner, *Parsifal.*

. . . looking young and attractive and
altogether unlike his early recollections of her.

Martin Gregor-Dellin, *Richard Wagner: His Life, His Work, His Century.*

Yet again the occasion for the dream was a real event. The day before . . .

Sigmund Freud, *The Interpretation of Dreams.*

. . . he had received . . .

Charles Dickens, *The Old Curiosity Shop.*

. . . a photograph of his mother as a young woman.
He looked at it, long and closely, remarking in a scarcely audible tone:
“Fantastic!” Was this the bond of trust and the sense of “I” connecting
mother and newborn, old man and “Ultimate Other”?

Lawrence J. Friedman, *Identity’s Architect: A Biography of Erik H. Erikson.*

8. The musical score for the movie *Dr. Zhivago* was written by Maurice Jarre, a French composer.

9. Both the book and the movie *Dr. Zhivago* open with the funeral of the boy Zhivago’s mother:

“On they went, singing ‘Eternal Memory’, and whenever they stopped, the sound of their feet, the horses and the gusts of wind seemed to carry on their singing. Passers-by made way for the procession, counted the wreaths and crossed

themselves. Some joined in out of curiosity and asked: 'Who is being buried? – 'Zhivago,' they were told. 'Oh, I see. That explains it.' – 'It isn't him. It's his wife.' – 'Well, it comes to the same thing. May she rest in peace. It's a fine funeral.'"

Additional Thoughts about The-Movie-Theater as Metaphor

At a therapy session I had on September 26, 2019 I related the following:

I spend a frightening amount of time in a semi-psychotic haze, sitting on a park bench listening to music. I just watch people pass by. I watch the world go by as the world moves on. It reminds me of Freud's analogy for free association. He talked about a person on a moving train, describing everything he sees in the terrain to a companion. I guess I'm talking about therapy when I talk about sitting on the park bench. I'm talking about the frightening amount of time I have spent in a chair in a therapist's office over the past 27 years. It never goes anywhere.

I think about how my life is so empty but I have this constant swirl of thoughts in my mind. I told you how I feel I have a civil war in my head. That's constantly going on. But I am not a part of the real world. I am detached from the world. I think about how in my adult life I have recreated the world of the infant in his crib. So his mother has gone off and the infant is alone in his bedroom. But he has this imagination. And he imagines the world of experience, but he is at the same time detached from real experience. And he has a flood of imaginings, of thoughts both satisfying and distressing. But it's all in his imagination. I feel like that in life. I have this inner movie theater in my mind. I spend my life inside that movie theater and the world goes by outside. But I am in the theater, engrossed in the movie. And in the movie there is a procession of characters, and some of them I like and some of them I don't like.

It reminds me of that dream I had [The Dream of Schubert's Final Piano Sonata]. I told you about that experience I had back in May 1980. I was living in

Spokane, Washington. And I went to the movie theater, and there was a volcanic eruption outside, but I had no idea what was happening outside in the real world. I was inside the movie theater, engrossed in the movie. My life is like that. I am in my private inner movie theater, while life passes by outside and I am oblivious to that world outside.

Is it possible that this therapy narrative is an expression of the struggles of the artist: a split between my creative self (as symbolized by the “inner movie theater” – *the private world where the reality sense is held in temporary abeyance until it is reinstated*) and my ordinary world of social stereotype (the world outside the “movie theater”)? Does the therapy narrative express a split in my sense of identity?

Marshall Alcorn writes: “The work of Greenacre suggests that the ‘identity of the artist may be more fluid or multiple than the identity of others. Gilbert Rose summarizes: ‘The intensity of all experience of the child of potentially great talent means that all the early libidinal phases tend to remain more lively, to overlap and communicate with each other more readily. The unconscious mechanism of splitting has in part become developed as a conscious ego device. The gifted person, while knowing the conventional sense of reality is thus also able to hold it in abeyance in order to explore and concentrate full powers of integration on imaginative possibilities. The artist’s selfhood is not unitary: there are two or more selves. There is a lively if often adversarial two-way conscious communication between the self-organizations—both between the conventional and creative identity as well as within the private world where the reality sense is held in temporary abeyance until it is reinstated.’” Alcorn, M. *Narcissism and the Literary Libido: Rhetoric, Text, and Subjectivity*.

In The Dream of Schubert’s Final Piano Sonata did my association to the movie theater express a split or struggle between my creative self and the

ordinary world outside? Is this struggle between the conventional or social self and the creative self a cause of another kind of split: a split in my sense of identity?

Therapy Session: September 4, 2018

The ontogenetic development of the mind proceeds by way of "mirroring." The two worlds external to the mind: the world of the body and self, and the world of the environment outside the body, must be internalized and stored as mnemonic images—those basic units of the mind's inner world that, as in Plato's parable of the Cave, represent sensory, largely visual, reflections of the Real. The mother/child relationship of the narcissistic period sets the foundation for the development of mind as well as of identity.

—Leonard Shengold, “The Metaphor of the Mirror.”

Elaine: Wait a minute. Wait a minute. I know what's going on here. Skinny Mirrors!

Jerry: What?

Elaine: Skinny Mirrors! Barney's has Skinny Mirrors, they make you look, like, 10 pounds lighter. This is false . . . reflecting!

Jerry: Oh, you're crazy.

Elaine: Am I?

—Seinfeld, “The Secretary.”

In a previous letter I observed the following about my therapist:

I wonder about the following possible underlying unconscious schema in the therapist: In the therapist's mind, perhaps factually right statements and beliefs – are also “morally right or good.” A factually wrong observation or belief is “morally wrong or bad.” Is it possible that in the therapist's unconscious, the dichotomy of Right and Wrong in a factual sense is fused with Right and Wrong in a moral sense? To be right factually is to be good and right morally. To be wrong factually is to be bad and wrong morally. Transference is morally wrong because it is factually wrong (it is bad); it does not reflect Truth. Subjective bias is morally

wrong because it is factually wrong. Perhaps, "Your letters are biased, they are projections, they are transference; that is, they are factually wrong. Your letters, since they are factually wrong, must also be morally wrong. Your letters are morally wrong and sinful and bad." Psychoanalysis emphasizes the analysis of irrational transference (the patient's projections) and intrapsychic fantasy. These ideas are factually wrong (they are irrational); therefore, psychoanalysis is morally wrong, bad and sinful.

I devoted the present therapy session to talking about my social problems, going back to childhood. The therapist ignored the psychodynamics of my reported social problems – that is, how my developmental experiences and internal dynamic processes might play a role in my difficulties in forming relationships – and, instead, focused on cognitive issues that might impair my social functioning. At one point she suggested that perhaps I had difficulty interpreting social cues, with the implication that my conscious mental representations about other people were “factually inaccurate;” my conscious mental representations did not correspond to objective reality. At another point the therapist said that my mother’s lack of empathy had caused me to generate flawed internal schemas that impaired my ability to gauge social situations accurately – again, focusing on the “factual accuracy” of my conscious perceptions of others. Late in the session, when I discussed problems in my relationship with my former primary care doctor, the therapist focused on the “facts” of the relationship – namely, how I inaccurately *mirrored* him cognitively, namely, how I imputed motives to the doctor for which there was no hard evidence – rather than the psychodynamics of my perceptions of the doctor and the nature of my affective investment in him, which centered on mirror-, ideal- and alter-ego hunger: problems of *psychic mirroring*.

In sum, the therapist focused on possible disturbances in conscious thought process and perception that impaired my ability to understand the reality of other people rather than on the psychodynamics of my personality and the effects of adverse developmental experiences on my

affect and sense of self. It was as if the subtext of the therapist's interventions was the following: mental health and social adjustment center on accurate conscious perceptions of others – accurate conscious perceptions of others will ensure healthy social adaptation.

But is it not disturbances in *affect* and *sense of self*, rather, that go to the core of my social problems in which important roles are played by *social anhedonia* (impaired ability to derive pleasure from social relations); *characterological depression*; lack of social interest; a tendency to *intense primitive idealization* and associated *mirror hunger*, *ideal hunger*, and *alter-ego hunger*; and *introjective depression* involving unconscious guilt and self-criticism and a perverse preoccupation with self-definition and self-worth (namely, problems in sense of self or *self-image*)?

And then, is there any evidence that my perceptions of others are, in fact, flawed? Might my developmental experiences and social reactivity have set me up for a heightened sensitivity to social cues? What is the effect of heightened social reactivity and intuitive giftedness, if any, on social adjustment? That is to say, is my problem that I inaccurately *reflect* others like a distorting mirror or is it that I have unusual insight into other peoples' subjectivity: *the people behind the mask*?

Researchers have observed in some persons an inborn talent and need to discern the feelings and motivations of others (intuitive brilliance); the trait was innate and had positive value, and should properly be termed a gift. Much as one would refer to the mathematically gifted person or the musically gifted person such persons display cognitive giftedness in the area of self- and other-perceptiveness called "personal intelligence." Park, L.C. and Imboden, T.J., et al. "Giftedness and Psychological Abuse in Borderline Personality Disorder: Their Relevance to Genesis and Treatment."

I had the sense of the therapist at this session that she did not see me as a

whole person – a singular individual with internal dynamic processes and feelings – but rather simply as a flawed mirror or camera that generates corrupted and maladaptive *conscious* object representations.

PATIENT: Last time, I said I wanted to talk about the issue of shame. I said that maybe I had feelings of shame about my difficulties in forming relationships. Maybe I feel defective in some way, and my difficulties in forming friendships highlight the fact that I have these defects. I don't know. I don't know if I even feel shame about my social problems. And, then, how I felt in childhood, I don't know at all how I felt – whether I felt shame or not.

I want to start off with an anecdote about something that happened fairly recently. It's a kind of perfect example of my problems with people. It shows how I interact with people, but then, nothing materializes. That's what I experience again and again. I interact with people but nothing materializes.

So this goes back a couple of years. I made a friend on Facebook. We chatted on Facebook from time to time. He was a smart guy. He worked for the Defense Intelligence Agency. He was in some kind of military intelligence. (He was sent to Afghanistan for a while.) Anyway, at one point, I said to him, "How about if we get together for lunch?" So we got together for lunch. And it was pleasant enough. I could see doing it again some time. But he seemed uncomfortable with me. That's what I sensed. Maybe I was being paranoid. But then, later on, I asked him if he wanted to have lunch with me and he would be non-committal. I asked him a few times if he wanted to go to lunch again. And he was always non-committal, and so, we ended up never going to lunch again. And then, he left Facebook and I haven't had any contact with him.

When I was a kid – maybe 7 or 8 years old – I had a friend named Chris. I still remember the day he moved in across the street. You know, it was a

kid my age and I was eager to be friends with him. And it was I who went over to his house and introduced myself. So even as a kid I was making an effort to have friends. It wasn't as if I cowered in fear of other kids. I wanted to have friends and made an effort to have friends. I remember the day he moved in. I still remember that. His mother said to me at one point, "Chris is busy now. We're busy unpacking. You and Chris can play later." I still remember his mother's name; it was Dolores. So Chris and I became friends and we played a lot. But then there was this other kid named Robert. And it always happened that when Robert was around, Chris would always play with Robert, and Chris and Robert would leave me out. They didn't seem to want to play with me. One time they were playing with me and they actually dumped me. So that made me feel bad when I was a kid.

THERAPIST (*who also happens to be the Director of the Clinic who oversees a staff of therapists*): Why do you think they didn't want to play with you? Is it that you were bossy? Did you try to boss them around?

[Note the assumption the therapist makes – without any evidence. She seems to be saying, "If other people react negatively to you, it is because you are to blame. I, the therapist, immediately think of the possibility that people react negatively to you because you engage in (a) bad acts over which (b) you have control." The therapist seems to focus on behavioral reasons for problems in social adjustment rather than possible psychological reasons: problems over which the patient may not even be aware and over which he has no control. These same behavioral assumptions play a role our therapy work. "If you take risks with people (that is, if you engage in positive behaviors), you will form friendships." The therapist's emphasis on behaviors parallels her technique of emphasizing the importance of a patient's cognition (perceptions and beliefs), neglecting the important role of a patient's internal mental processes and identity.]

I am reminded of a previous letter I wrote, dated June 19, 2018, that recorded an identical schema in which the therapist assumed, without evidence, that if others react negatively to me it is because of (a) my bad acts over which (b) I have control:

At one point in the session I said that some of my previous therapists were "nasty" toward me. She immediately opined, with no evidence, "Maybe they acted that way because of your letters, I don't know." Why is that statement not a projection by the therapist onto my previous therapists? She seems to be saying, "I have negative feelings about your letters. It is probably also the case that your previous therapists had the same reaction I have. (That's the projection! Is she not saying, "I am rational and all your previous therapists were rational; I and your previous therapists have access to the same rationality, the same Truth.")" All therapists will react negatively to written criticism? That's factually untrue. Dr. Abas Jama, my psychiatrist in 2009-2010, said about one of my highly critical letters concerning him: "I read your letter. It was well written. You put a lot of thought into it. It showed very good thinking." Dr. Jama was a mature and secure medical doctor; he was not going to be flustered by something a mental patient wrote about him.

There is another implication to the therapist's statement, "Maybe they acted that way because of your letters, I don't know." The statement suggests that the therapist believes that if other people react negatively to me it is a rational and objective response to my "bad acts" – and not a result of subjective bias or irrational animus (counter-transference) by that therapist. She seems to say that authority figures will only react to me negatively because I provoke them. That raises questions about the sincerity of a solicitous statement this therapist made at the very first session after I told her that my father used to beat me when I was a boy: "He shouldn't have done that. You were just a child. Children misbehave. You did nothing wrong." Why wasn't the therapist thinking at this session, "Your past therapists were acting irrationally. They should not have reacted to you negatively. You were just a vulnerable therapy patient who was using writing as a form of self-soothing. Additionally, people with psychological problems sometimes act out. You did nothing wrong, as Jama recognized." It's as if at this session I was

no longer the 'good object' (an innocent child) as I was at the first session. Rather, the therapist transformed me into a 'bad object' whose legitimate use of writing as a self-soothing measure aroused a paranoid response from the therapist, who was now the victimized 'good object.'"

PATIENT: No, that wasn't it at all. It's not that I bossed other kids around. The problem, as I see it, was that I would sort of tag along with other kids. I wasn't the type of kid who would initiate things. I never came up with ideas for different kinds of games.

Then, in the sixth grade I joined a choir. That was when I was 10 years old. The choir was sponsored by the Philadelphia School District. We had choir practice every Saturday morning. There was another kid in my class who was a member of the choir. When he found out I joined, he said we could go together to choir practice. So we became friends. We went to choir practice every Saturday morning together, and afterwards, we would go back to his house. His mother used to make lunch for us. They were German immigrants. They owned a bakery. I still remember the iced tea his mother made every week. We had our pick of pastries from the bakery. Sometimes we went to the movies after lunch. (The Esquire Theater was just a few blocks away.) I really liked that. There was another kid, a mutual friend, who also belonged to the choir. And one week the three of us got together. I remember we went out to the woods and played out there. Apparently, they didn't consider me very much fun to play with. A later time, after choir practice, the two of them got together but didn't let me go along. My friend told me I just wasn't any fun to play with. I think he said that I didn't know how to play. So that's what happens with me. I just don't generate any social interest with people.

[Note the recurrent issue of triangulation. In early childhood, two friends excluded me. Then, later, at about age 10 or 11, two friends excluded me. The therapist missed this issue of triangulation. Triangulation is an

important feature of dysfunctional families and narcissistic relationships.]

When I was ten years old, I made another friend. We got to be very friendly. I went over his house a lot. We used to get together on Saturdays. It was a different kind of friendship, an intellectual type friendship. He was very smart. He was a National Merit Scholar. You know what that is? His older brother got a Ph.D. in engineering from Harvard. His brother teaches at Brown University now; he was brilliant. So that was an intellectual kind of friendship. That lasted till when I was in the tenth grade in high school. Then I kind of lost interest. That's another thing about me. I can lose interest in people. You talk about the idea that I need to take risks with people, but that goes to the issue of forming relationships. But you ignore the issue of maintaining friendships once you form them. (It's as if you're concerned about me getting on a train. But even if I get on a train, there's no guarantee I'll stay on the train for the whole trip. I might just decide to get off at the next stop.)

Then, in high school, it was in the eleventh grade. We had a year-long class project. The teacher broke us up into small groups. We worked together on the project in the small groups. I remember, it was in October. And one of the kids in the group asked me to join him on a Saturday at his house with another kid who was in our group. So I went over to his house. And it seemed to me that for them it was a kind of social thing. They just wanted to goof off. They weren't serious about the project. They were just using the project as an excuse to do social stuff. That turned me off. I take things seriously. I went to the kid's house to work on a school project – not for social stuff. Well, that was in October – and the project was meant to go all year – but they never asked me to join them again.

[Again, there is an issue of triangulation.]

I want to tell you something really uncanny. So this was in early November 1988. I was working at a law firm at that time. And Craig, another guy Daniel Cutler, and I went to lunch together. I guess I made a good impression because Craig said to me: "Stop over my place anytime. I live near your office." He lived in Adams-Morgan and I worked at DuPont Circle. "Stop over my place anytime. I'm always home. You don't even have to call first." Well, I don't think he was sincere about that. Nothing ever came of that.

[I had previously noted that Craig had a phallic-narcissistic character. He was self-confident, arrogant, elastic, vigorous and often impressive.

According to Blatt, both phallic narcissists and introjective depressives (like me) are concerned with self-definition. "A patient with an introjective (guilt-ridden) depression is also concerned about self-definition as expressed in exaggerated feelings of guilt, transgression, wrong-doing and failure. Phallic narcissism is the reciprocal [or *mirror image*] of introjective depression in that the individual takes excessive pride in the self and his accomplishments." Blatt, S.J. "Representational Structures in Psychopathology."]

But here's the really uncanny part. So a year later, in early August 1989, and I was still working at the same firm, and we had a Happy Hour at a bar in Adams-Morgan, Stetson's, and there was this other paralegal there: Jesse Raben. So Jesse Raben said to me: "Stop over my place anytime. I live near the office, on New Hampshire Avenue. I'm always home. You don't even have to call first." Well, you have no idea! That struck me as so uncanny! That two people should have said the same thing to me: the same phrases. I don't know what to make of that. So nothing ever came of that either.

[Did I form the unconscious sense that Craig Dye and Jesse Raben had lied to me or betrayed me; that their social overtures were insincere; that they had, figuratively speaking, committed social *perjury*?]

THERAPIST: Maybe you have a problem interpreting social cues.

[I found the therapist's response remarkable. The observation was not simply tangential; it was a *non sequitur*. The therapist failed to address the quality of my relationships; apparently recurrent social difficulties; my feelings; or the possible relationship between, on the one hand, adverse developmental experiences and, on the other, difficulties in forming relationships (it is well-recognized that child abuse victims frequently "don't know how to play" and are pseudo-mature, like "little adults"). Instead, the therapist concentrated on possible distortions in my *conscious* perceptions of others: the possibility that, like a flawed camera, I failed to accurately *mirror* others through the aperture of my cognition.

The therapist did not assess the possible role of *social anhedonia* in my social adjustment problems and the possible relationship between social anhedonia and adverse childhood experiences. See, e.g., Frewen, P.A. "Assessment of anhedonia in psychological trauma: development of the Hedonic Deficit and Interference Scale."

The therapist did not assess the possible role of *characterological depression* in my social adjustment problems and the possible relationship between characterological depression and adverse childhood experiences. See, e.g., Gibb, B.E. "Emotional Abuse, Verbal Victimization, and the Development of Children's Negative Inferential Styles and Depressive Symptoms."

The therapist did not assess the possible role of *withdrawal* and *confused identity* in my social adjustment problems and the possible relationship between withdrawal and confused identity and adverse childhood experiences. "[P]hysical, social and verbal abuse may provoke in the already vulnerable and shy child strong feelings of being unlovable, inferiority, shame (and linked self-hate) and frustration. This might bring

about attachment and associated social interactional problems which, in turn, could contribute to loneliness and [schizoid] etiology.” “[E]motional abuse/neglect might cause deep feelings of inner emptiness and a blurred and/or *confused identity* that can be observed in many patients with [schizoid disorder].” Martens, W.H.J. “Schizoid personality disorder linked to unbearable and inescapable loneliness.”

The therapist did not assess the possible role of *guilt* and *self-criticism* in my social adjustment problems and the possible relationship between *guilt* and *self-criticism* and adverse childhood experiences. Blatt recognized that these psychological problems may stem, in part, from a past in which important others have been controlling, overly-critical, punitive, judgmental, and intrusive—thus creating an environment in which independence and separation was made difficult.

Instead, the therapist suggested that I might have a problem interpreting social cues. That assumption is, in fact, largely untenable. First, there is no specific evidence that my ability to interpret social cues is impaired. Second, psychological testing disclosed that I have high executive functioning. I had a perfect score on the Wisconsin Card Sorting Test (WISC). High executive functioning is associated with an unusual ability to ascribe mental states to others; the ability to model and understand the internal, subjective worlds of others, making it easier to infer intentions and causes that lay behind observed behaviors; and an unusual ability to judge the emotion in another person’s gaze. Decety, J. and Moriguchi, Y. “The empathic brain and its dysfunction in psychiatric populations: implications for intervention across different clinical conditions.” A perfect WISC score is associated with high emotional intelligence. Emotional intelligence is a set of competencies that enable an individual to engage in sophisticated information processing of emotions and emotion-relevant stimuli and to use this information as a guide for thinking and behavior. Alipour, A. “Emotional Intelligence and Prefrontal Cortex: a Comparative Study Based on Wisconsin Card

Sorting Test (WCST). *The therapist's suggestion that I might have an impaired ability to read social cues or that I have impaired emotional intelligence is an unrealistic assumption in view of my psychological test results. Further, the therapist failed to address the paradox of why a patient with high emotional intelligence would experience problems in social adjustment.*

Note also that adverse childhood circumstances can actually enhance executive functioning. Mittal C. "Cognitive adaptations to stressful environments: when childhood adversity enhances adult executive functioning." The authors found that adults who grew up in uncertain environments had a heightened ability for cognitive shifting, a mental process of *consciously* redirecting one's attention from one fixation to another.]

[At another point in the session I related the following anecdote.]

PATIENT: I want to tell you something that happened to me when I was about seven years old. I used to like to ride my bicycle around the neighborhood. So, one time I was riding down the pavement on a street (Smedley Street) near me, and an older kid came by and threatened me. He said, "This is my street. I don't want to ever see you on my street again. If I ever see you on my street again, I'm going to beat you up." I got scared and when I got home I told my mother. My mother wasn't at all empathic. She said, "He's a bully. He likes to threaten people. That's what bullies are. They threaten people. He's not going to beat you up. Bullies are all talk. Don't ever be afraid of bullies." So I felt bad. I thought my mother would say something that would make me feel better [that is, soothe me], say something that told me that she understood what I was feeling. And instead, I got a lecture from my mother on how to deal with bullies.

[The therapist proceeded to explain that when a mother fails to respond to a child's painful mental states, there may be a cascade of events that will

adversely affect a child's cognitive abilities. The therapist said that my mother's lack of empathy had caused me to generate flawed internal schemas that impaired my adult ability to gauge social situations, or dangers, accurately – again, focusing on the idea of “factual accuracy” of my conscious perceptions of others. The therapist's explanation, in fact, jibes with the literature: “When parents (or other primary caregivers) are protective and comforting, children are kept safe while they learn to recognize and respond to danger. This promotes gradual adaptation and brain development which is the basis of resilience in the face of threat. When parents themselves are the source of threat or when they fail to provide comfort, children may rely on psychological ‘shortcuts’ and reflexive responses. Shortcuts simplify complex conditions by omitting or transforming information. The most frequent shortcuts are over-generalization of instances such that they are treated as universally present and reductionist assignment of blame exclusively to one party in a dispute.” Crittenden, P.M. “The Roots of Chronic Posttraumatic Stress Disorder: Childhood Trauma, Information Processing, and Self-protective Strategies.” In plain English, the mother (or other caregiver) plays an important role in helping a child moderate threats and painful emotional states – and in promoting mature cognitive abilities that permit the adult to accurately gauge threatening situations.

However, there are several problems with the therapist's intervention. The therapist pointed to only one possible outcome of a mother's failure to comfort a child.

First, there is no evidence that my ability to gauge social situations or social dangers is impaired.

Second, mother's failure to comfort does not necessarily lead to a maladaptive outcome in the child. In some children – children with unusual creative capacities – mother's failure to comfort can lead to an *adaptive* response.

A child's creative capacities are one avenue toward transforming one's self-states – that is, states of overstimulation, depletion, or threatened dissolution. The subjective discomfort of a child's painful self-states can provide the child an impetus for finding the means by which such states can be altered on his own. Such transformations are a form of self-righting and self-regulation. A mother's failure to comfort a child and thereby help moderate the child's self-states can enhance the child's own self-regulatory capacity, enabling him to shift toward greater cohesion by himself without resort to attachment objects. Think about it: When my mother died, at the beginning of my second semester of law school, I continued on and completed my first year at the top 15% of my class. When I was fired from my job, I didn't respond with angry protests; I simply packed up my belongings and left the premises. I appear to have the creative capacity to deal with painful self-states on my own. I may have developed that adaptive ability in childhood in reaction to an unempathetic mother. Lachmann, F. *Transforming Aggression: Psychotherapy with the Difficult-to-Treat Patients*.

The therapist's interventions highlight the problem of a therapist who has limited knowledge and who applies that knowledge haphazardly on her assumption that that limited knowledge will apply to all patients, as if all patients constituted an undifferentiated mass of persons who lacked any individuality: as if patients did not fall into distinct *categories*.

But there is more than this.

The therapist in this intervention assigned the mother the role of the child's *tension reliever*. In situations where the child is struggling with painful emotions of overstimulation, depletion, or threatened dissolution (self-states), the therapist assigns the mother the responsibility of responding with empathy to modulate the child's painful feelings. In the therapist's view, the mother's role is to restore the emotional balance of

the child and thereby promote mature cognitive capacities: namely, a mature adult ability to gauge adverse circumstances realistically – in a sense, like a *camera* accurately recording objective reality, a camera that records accurate object representations that will be accessible to the individual's conscious mentation.

In so doing, the therapist ignores the role of the mother as a *psychic mirror*. According to Kohut's theories, individuals need a sense of validation and belonging in order to establish their concepts of self. When parents mirror their child, the action may help the child develop a greater sense of self-awareness and self-control, as they can see their emotions reflected in their parent's faces. Additionally, children may learn and experience new emotions, facial expressions, and gestures by mirroring expressions that their parents utilize. The process of mirroring may help children establish connections of expressions to emotions and thus promote social communication later in life. Children also learn to feel secure and valid in their own emotions through mirroring, as the parent's imitation of their emotions may help the child recognize their own thoughts and feelings more readily.

What Kohut is saying is that parents' failure to *mirror* a child may result in *disturbances of affect* and in *disturbances in sense of self*. What the therapist, on the other hand, is saying is that a mother's failure to respond empathically to a child may impair *cognitive development* and lead to an adult who cannot *perceive* reality correctly. *But what about the patient's feelings and sense of self?* As I have said before: We are not thinking machines. We are feeling machines that think. Also, what about a patient's sense of self: the specific nature of his strivings, ambitions, and ideals – all of the qualities that make him a singular individual? These qualities of the self (in conjunction with the individual's feelings) are the product of healthy *mirroring* – not the product of the child's experience of *tension relief* by mother.

The therapist's theoretical orientation has important practical significance as it relates to her therapy work with me. The therapist has a tendency to deny or distort my feelings and fail to respond to my sense of self (my identity). Rather, she seems to concentrate for the most part on her perceived role as a *soother of tensions* and as a referee of my perceptions of reality.

Kohut writes: "The self, the core of our personality, has various constituents which we acquire in the interplay with those persons in our earliest childhood environment whom we experience as [*mirroring*] selfobjects, [such as the empathic mother]. A firm self, resulting from the optimal interactions between the child and his selfobjects is made up of three major constituents: (1) one pole from which emanate the basic strivings for power and success; (2) another pole that harbors the basic idealized goals; and (3) an intermediate area of basic talents and skills that are activated by the tension-arc that establishes itself between ambitions and ideals." Kohut, H. "The Disorders of the Self and their Treatment: An Outline."

Kohut describes the *mirror-hungry* as individuals who desperately crave, in relation to others, restitutive relationships that will compensate for mother's empathic failures. "Such individuals frequently display a relational pattern characterized by primitive idealization of an unavailable other to shore up a fragile self-state." Kieffer, C. "Rstitutive selfobject function in the 'entitled victim': a relational self-psychological perspective."

Kohut states that in the mirror-hungry "[i]t may, for example, be helpful to the patient to understand the sequence of events, repeated on innumerable occasions, when as a child his need to establish an autonomous self was thwarted by an intrusive mother. At the very point, in other words, when the child required an accepting *mirroring* of his independence for the formation of his nascent self, his mother, because

of her own incompleteness and fragmentation fears, insistently tried to achieve an archaic merger [a “oneness” relationship]. Instead of serving as the source of a usable selfobject to the child, the mother provided an unmanageable and tyrannical selfobject which, among other ill-effects for development, left the child with an insatiable yearning for something that would allow him to feel whole and complete—something that he could only begin to define for himself in the non-intrusive atmosphere of the treatment situation.” Kohut, H. “The Disorders of the Self and their Treatment: An Outline.”

One wonders what Kohut would say about a therapist who, on innumerable occasions, intrusively insists on her rightness (both *factual* and *moral*) and on her authority, a therapist who disdains a mirror-hungry patient's need to carve out an autonomous space for self-expression through letter writing. One wonders what Kohut would say about a therapist who intrusively insists on foisting her own projective and need-satisfying interpretations on a patient who she barely recognizes through the fog of her image-distorting theoretical lens. One wonders what Kohut would make of a therapist who insists on denying a patient's feelings and symbolic imagery: “No, you don't feel alienation, you feel loneliness.” “No you don't feel like an extra-terrestrial alien. You feel like a lonely human.”

Unempathic mothering is not the only cause of mirror hunger, by the way. As a practitioner who works with trauma survivors, it might be useful for the therapist to think about how adverse or abusive childhood experiences will also promote mirror-hunger. “In the shattered self, the adult survivor of abuse with an *unmirrored* archaic self will invariably develop *mirror hunger* in which he yearns for someone to serve as a self-object to confirm and feed the famished self. The *mirror-hungry* survivor has an insatiable need for affirmation from others to confirm and validate his existence.” Sanderson, C. “Counseling Adult Survivors of Child Sexual Abuse.”

To recapitulate: In the therapist's interpretation, my unempathic mother left me with cognitive deficits, namely, maladaptive schemas that dispose me to misinterpret my environment, misinterpret social cues, and misinterpret adverse circumstances. That is to say, because of cognitive deficits resulting from unempathic mothering my ability to generate accurate conscious object representations, or accurately *image* other people, is skewed, thereby impairing my ability to form relationships.

My personality, life history, and symptoms tell a different story.

Psychological testing (Wisconsin Card Sorting Test perfect score) discloses high executive functioning with concomitant high emotional intelligence. I have an unusual ability to *image* other people's mental states. That is to say, I have unusual insight into other peoples' subjectivity: I am able to image the *people behind the mask*. My unempathic (and intrusive) mother left me with a craving for *mirror-image* objects; in the language of Kohut, I experience pathological *mirror hunger*. I display a relational pattern characterized by primitive idealization. At the same time, unempathic mothering provided an impetus for me to find the means to moderate painful feelings on my own. I show an unusual ability to self-regulate. I am able to shift toward greater cohesion by myself without resort to attachment objects.]

[Near the end of the session, I began to talk about my former primary care doctor, J.A.P–, M.D.

A *word of explanation*. When I saw Dr. P– in medical consultation for the first time on September 29, 2015 I had an unusual emotional response; I experienced an uncanny sense of the double, as if I were in the presence of my psychological mirror image, my alter ego.

On the evening of September 29, 2015 I had a striking dream: full of

feelings of nostalgia and loss, a dream that I experienced as deeply affecting. I was wandering alone and lost in a city in the state of Missouri with what I would describe as an insatiable yearning for something that would allow me to feel centered, whole and complete. Just today, as I was recording these thoughts, an interpretation emerged out of a remote association. Is it possible that the word *Missouri* is a play on words? We can imagine breaking *Missouri* into two parts: “miss” and “our I.” Might we interpret the word *miss* as relating to feelings of loss and nostalgia? Might we interpret the phrase, “our I” as relating to the notion of a shared identity: the self and a mirror image? Also, might we imagine that the sense of loss in the dream was overdetermined? I was both physically lost in a place I had never visited before and I was also mourning the loss of something from my past: fragments of Self and Other. (I told my then treating psychiatrist, Alice E. Stone, M.D., about this dream in 2015. I remember telling her: “The only thing I can associate to is the killing of Michael Brown in Ferguson, Missouri, in 2014.”)

In the days that followed – and continuing for months on – I began posting items on Twitter about Dr. P— : imaginary conversations between him and me, humorous items, as if I had transformed him into a literary alter ego. In a lengthy letter dated December 29, 2015 I told my then-treating psychiatrist that I had formed an idealizing transference with Dr. P—: “I have formed an idealizing transference with my primary care doctor, Dr. P—, that complements my negative transference to you. An examination of my psychological background reveals that my transference reactions to my primary care doctor and you, respectively, appear to be a derivative of my childhood experiences and my early psychological relations with my parents.”

In mid-June 2016, Dr. P— learned of my Twitter, or so he claimed, and allegedly became alarmed; in an affidavit he filed with Superior Court in support of a protection order against me, he declared that he was afraid of me and that my actions in relation to him – namely, my posting items

about him on Twitter – constituted Internet stalking. In late July 2016 Dr. P— and I appeared in Superior Court at which time I consented to a one-year protection order without admissions. Thereafter, in March 2018, I filed a criminal complaint against Dr. P— with the FBI charging that Dr. P— had not, in fact, been afraid of me; that he had not really believed that I was stalking him; and that the affidavit he had earlier filed in Superior Court in support of the protection order had been perjured.]

PATIENT: So you mentioned that maybe I have a problem interpreting social cues. I don't know. I think I'm very sensitive to social cues. You remember that criminal complaint I filed against my primary care doctor? You can read about that in the documents I gave you. I gave you a copy of that. Well, I want to talk about something that I never talked about before – something that happened on the day we appeared in court together in late July 2016. I noticed that he never made eye contact with me – he seemed to avoid all eye contact with me. When he first walked into the courthouse, and I was sitting in the lobby outside the courtroom, he saw me, but after that, he never looked me again – ever. I mean we were sitting across from each other in the courtroom. I was on one side of the aisle; he was on the other. From time to time I turned to look at him, but he had his body turned away from me and toward his lawyers. (I noticed his shoes; they appeared to be Sperry Top-Siders. He wasn't wearing a necktie. And I thought, "Who appears in court dressed like that?") I noticed his lawyers glance at me. But never him. It struck me as odd at the time, the fact that not once would he look at me. I thought, "Is it possible that he has feelings of shame about what he did?"

[Note that I had referred to the issue of shame at the very beginning of the session, then abandoned the topic: "Last time, I said I wanted to talk about the issue of shame. I said that maybe I had feelings of shame about my difficulties in forming relationships. Maybe I feel defective in some way, and my difficulties in forming friendships highlights the fact that I have these defects. I don't know. I don't know if I even feel shame about

my social problems. And, then, how I felt in childhood, I don't know at all how I felt - whether I felt shame or not." Was I now projecting shame onto Dr. P-?]

Then, each of us, my doctor and I, had to speak to a mediator to decide on what we wanted to do. I met with the mediator first in a little room next to the courtroom. She went through the different options I had. When she said I could consent to a protection order without admissions, I leaped at the chance. I thought, "I could have a hearing, but if I lost, I would be labeled a stalker." (I remember the mediator saying, "With a hearing, you can win big. But you can also lose big.") And I didn't want to be labeled a stalker. So I took the option of accepting an order, but not admitting to anything. So, now, technically, I did nothing wrong. The bottom line is that my accepting the order avoided a hearing. So then we went back to the courtroom, and the mediator and the doctor left the courtroom together and met in the little room, and she explained my decision to him. Sometime later – and I was sitting in my seat in the courtroom – the door opened at the back of the courtroom, I turned around to look, and it was him, and he was kind of beaming. He had a smile on his face. I thought: "He looks happy. It's as if he never wanted to go through a hearing where he would have to testify against me." Then, at the very end, after the proceedings, the court said he and his lawyers could leave, and I had to stay about 20 minutes behind, so that he and I would have no contact. I turned my head and looked at him for a moment as he stood to walk out; then I turned around again and, not looking at him, I could see, as he was walking out toward the door, he turned around to gaze at me for a moment. It's as if he wanted to get one last look at me, knowing he would never see me again. At least, that's what I thought. I saw that as a friendly gesture. And I wondered why somebody who claimed he was afraid of me, somebody who, one would think, had ill-will against me, would do that. Why would he have tried to get one last look at me, as if he was parting from somebody he liked?

Then in February of 2018, over a year after the order, I started thinking about these things (because my previous therapist had mentioned at one of our sessions that my doctor said he was afraid of me) (my writings indicate that this occurred at my therapy session on February 12, 2018). I started thinking about what had happened in the courtroom that day. And a light went off in my head. I put all these things together. And I thought, “there’s no way he was afraid of me. He must have been put up to this by his lawyers.” *I had the feeling that he was just a passive player in somebody else’s agenda.* It was my idea that his lawyers put him up to this. Less than a month later, in March, I filed a criminal complaint against him, alleging he committed *perjury*. I am convinced his lawyers were behind the protection order. *He was just a passive player in somebody else’s agenda.*

[My statement, “I had the feeling that he was just a passive player in somebody else’s agenda” is striking. The statement directly parallels observations I had made earlier in the session about my childhood social difficulties: “I would sort of tag along with other kids. I wasn’t the type of kid who would initiate things. I never came up with ideas for different kinds of games.” My attribution to Dr. P— amounted to the following: He was a passive party who “tagged along” with his lawyers. “He didn’t initiate” the protection order. The doctor did not “come up with the idea” for the “courtroom games.” Clearly, my attribution to Dr. P— was a projection.

Note also that I imputed a triangular relationship between the doctor, his lawyer and me.

What is the psychological significance of my projection? What does that projection say about my psychological relationship with Dr. P—; about my sense of my social difficulties; and about my *mirror hunger*? Why did my thoughts at this session – devoted for the most part to my recollections of my childhood social problems – turn at the end to remote concerns about

my adult relationship with my primary care doctor?]

PATIENT: So I think I was very sensitive to what was going on with my doctor. I picked up on all the social cues in the courtroom. At least, that's what I think.

THERAPIST: You may be very perceptive, but that doesn't necessarily mean that you interpret what you see correctly. You are certainly intuitive. But you might misinterpret the things that you notice.

[The therapist and I got into a give-and-take about my belief that Dr. P— had lied about me in a sworn statement: that he had committed *perjury*. She reinforced the idea that the doctor was afraid of me. I interjected: “He *claimed* he was afraid of me.” She assumed the stance of an advocate for the doctor, countering my factual assertions with factual assertions of her own that supported the doctor’s allegations against me.

My exchange with the therapist remained on a factual level. She didn’t seem to see any psychological significance in my observations about my interaction with the doctor. She did not delve into my feelings about the doctor or any issues of psychological interest relating to the doctor. She did not appear to register my statement about Dr. P— late in the session, “I had the feeling that he was just a passive player in somebody else’s agenda” as a projection of my earlier statement about my childhood social problems: “I would sort of tag along with other kids. I wasn’t the type of kid who would initiate things. I never came up with ideas for different kinds of games.”]

Notes Upon a Type of Social Pairing Found in Some Creatively-Gifted Persons

Wilhelm Fliess was an ear, nose, and throat physician who was a close friend of Freud’s in the 1890s. Freud in Vienna and Fliess in Berlin met infrequently, but they carried on a voluminous correspondence. Fliess

developed the fear that Freud had plans to kill him. Fliess asserted that Freud was plotting to murder him by pushing him off a precipice during one of their walks. No credence is given to Fliess's fear, which the few scholars who now know of the episode consider a figment of Fliess' paranoia. Fliess claimed that Freud had stolen Fliess's idea about bisexuality. Blumenthal, R. "Scholars Seek the Hidden Freud in Newly Emerging Letters." The alleged plagiarism was an act of intellectual theft that enraged Fliess. One report raises the possibility that Freud's plagiarism was knowing and deliberate: "At Achensee, Fliess accused Freud of stealing the idea of bisexuality, which Freud was then using to explain homosexuality. He reminded Freud he had told him about it in 1898, a conversation Freud claimed to have forgotten. Later, Freud recanted, conceding that Fliess should get the credit. After the Achensee meeting, Freud proposed they collaborate on a book about the subject. By then, Fliess was wholly unreceptive. Their denouement was nigh." Goleman, G. "New Insights into Freud."

According to the psychoanalyst Heinz Kohut, the Freud-Fliess relationship is not unique or idiosyncratic. Rather, it is an exemplar of a typical pairing that can occur between a creative person in creative crisis (ego enfeeblement) who requires a comrade with the personality traits of notable narcissism and perhaps paranoia. See, Kohut, H. "Creativeness, Charisma, Group Psychology. "Kohut's interest clearly goes way beyond the specific case of Fliess and Freud, as his real concern is to figure out what self-functions the Fliesses of the world have for the Freuds of the world in periods of psychological enfeeblement. Kohut asks, as he moves deliberately from Freud's biography to psychohistorical analysis: 'What are the characteristic features of the person who is especially suitable to become the admired omnipotent selfobject for the creative person during the period when he makes his decisive steps into new territory?' The answer is surprising. It seems the others in these relationships must possess 'unshakable self-confidence' and express their opinions with an 'absolute certainty' bordering on paranoia." *The Leader: Psychological*

Essays.

"What mattered for Freud, Kohut argues, was a 'transference of creativity' of his narcissistic, or self, needs. Freud came to require the imagined presence of Fliess as a crucial participant in his own inner struggles as he gained his great insights in human psychology in these years. It was, however, a scary process of discovery for Freud, filled with loneliness, doubt, and despair. During the years of discovery, Freud was in fact enfeebled and at the mercy of powerful forces that he could not fully control. Much biographical evidence about Freud in this period of creative struggle supports Kohut's insight. . . . Kohut also turns to biographical, literary, and artistic work on other geniuses during their creative struggles to extend his insights into Freud. Kohut was thus very interested in the way Picasso sought out Georges Braque during the discovery of cubism, especially the way he built up Braque in his mind as his alter ego (much like Freud exaggerated the genius of Fliess during the years of their intense personal connection). At the height of Picasso and Braque's mutual exploration of the new art form, their paintings became virtually indistinguishable." The Leader: Psychological Essays.

In short, the Freuds of the world seem to need a counterpart who is narcissistic and who possesses near paranoid self-confidence. One might speculate, invoking Kohut, that Fliess's pre-existing paranoid trend was something that attracted Freud to Fliess at the outset – something that Freud might have picked up on based on Freud's intuitive giftedness, that is, his exceptional ability to sense psychological characteristics of significant others in their lives. It has been found that some persons have an inborn talent and need to discern the feelings and motivations of others. Much as one would refer to the mathematically gifted person or the musically gifted person, some persons have a cognitive giftedness in the area of self- and other-perceptiveness called "personal intelligence." Park, L.C. and Imboden, J.B., et al. "Giftedness and Psychological Abuse in Borderline Personality Disorder: Their Relevance to Genesis and Treatment."

Did I induce Dr. P– to play a necessary complementary role for me

through projective identification – a role I needed him to play in order to support a “transference of creativity” of my narcissistic, or self, needs?

I had met Dr. P– in September 2015. The previous year, in January 2014, I had begun a novel (*The Emerald Archive*) that I completed in 2018. The novel was experimental, and featured a highly original structure. During the entirety of my escapade with Dr. P– (September 2015 to June 2016) I worked intensely on my creative work, my novel. Indeed, I ultimately incorporated Dr. P– into the novel; one of the book’s characters, an individual I named Moses Haim, was based on Dr. P–. Did Dr. P– possess the characteristic features of the person who is especially suitable to become the admired omnipotent selfobject for the creative person during the period when he makes his decisive steps into new territory?

The analyst Leonard Shengold reportedly said: “Fliess was a very charming and vivacious man, and Freud had a need and a terrible weakness for that kind of glamorous person.” Dr. P– was a glamorous and academically-gifted person, and I was attracted to those qualities in him. He and his wife had gotten married in an extravagant wedding in the Caribbean in 2014. Later, Dr. P– had a lengthy article written about him by a major metropolitan daily newspaper that featured a photograph of him and his wife. Dr. P– had an apparent appetite for fame and notoriety (not unlike Freud who hungered for the recognition of a Nobel Prize). I discovered the newspaper article the day I met him on September 29, 2015.

I also think of the Schreber case, a case well-known to Freud enthusiasts, in connection with Dr. P– and me. Freud speculated that an unconscious homoerotic tie to his perceived persecutor accounted for Schreber’s conscious paranoid thinking about another male. In Freud’s construction, Schreber transformed the unconscious statement “I love him,” *via* the defenses of projection and reversal, into the conscious statements “He hates me” or “He persecutes me” and “I am afraid of him.”

Dr. P— crafted a protection order affidavit based on a sexual reading of my nonsexual Internet posts about him that claimed or implied that I had a homoerotic tie to him, and that, as a consequence, he was afraid of me. Dr. P— oddly saw a sexual meaning in my references to “poker games,” “lunch at a kosher Vietnamese restaurant in Hanoi,” and my references to common breakfast items, such as, “eggs and sausages.” (*Eggs and sausages?*) Dr. P— also said he dreamed about me, indicating that he had some kind of unconscious emotional investment in me.

Is it possible that Dr. P— in fact liked me — that it was not just my fantasy but my reading of him based on intuitive giftedness (as opposed to defensive distortion) — and that his possible unacknowledged positive feelings for me were related to his professed fear of me?

The Dream of the Intruding Doctor

I am thrice homeless, as a native of Bohemia in Austria, as an Austrian among Germans, and as a Jew throughout the world. Everywhere an intruder, never welcomed.

—Gustav Mahler

In [his] brief novel[, *The Stranger*,] Camus presents a hero [who is] indeed an outsider, a stranger alienated not merely from society but also from himself.

—K. Lakshmi Devi, “The Stranger” by Albert Camus.

Only strange things had I ever seen, that which was near was friendless, as if I had never known it, was everything that came my way. But I knew you clear and true: when my eyes saw you, you were my own: what I harbored within me, what I am, rose like the day, . . . when in the frosty barren place I recognized my friend for the first time. . . . In the brook I recognized my own image, and now I perceive it again as once it rose from the water, now you offer my image to me.

—Richard Wagner, Die Walküre.

A child with absent, neglectful, or inconsistent caregivers who do not adequately mirror the child may foster the development of an adult who is mirror hungry and seeks out others to facilitate a feeling of being special.

—Cheri L. Marmarosh and Sandra Mann, “Patients’ Selfobject Needs in Psychodynamic Psychotherapy: How They Relate to Client Attachment, Symptoms, and the Therapy Alliance.”

The incest taboo is of course a necessary condition of the Oedipus complex According to Lacan, a child enters culture – becomes human – only as a result of an intrusion into the original bond with the mother. The intruder is typically the father.

—Andrew Collier, “Lacan, Psychoanalysis and the Left.”

[The primal sons] not merely hated and feared their father, but also honored him as an example to follow; in fact each son wanted to place himself in his father's position. The cannibalistic act thus becomes comprehensible as an attempt to assure one's identification with the [intruding] father by incorporating a part of

him.

-Sigmund Freud, Moses and Monotheism.

On August 9, 2014, Michael Brown Jr., an 18-year-old African American man, was fatally shot by a police officer, 28-year-old Darren Wilson, in the city of Ferguson, Missouri, a suburb of St. Louis. Brown was accompanied by his friend Dorian Johnson who was 22. Wilson said that an altercation ensued when Brown attacked Wilson in his police vehicle for control of Wilson's gun until it was fired. Brown and Johnson then fled, with Wilson in pursuit of Brown. Wilson stated that Brown stopped and charged him after a short pursuit. In the entire altercation, Wilson fired a total of twelve bullets, including twice during the struggle in the car; the last was probably the fatal shot. Brown was hit a total of 6 times from the front.

On the evening of September 29, 2015 I had a striking dream: full of feelings of nostalgia and loss, a dream that I experienced as deeply affecting. I was wandering alone and lost in a city in the state of Missouri with what I would describe as an insatiable yearning for something that would allow me to feel centered, whole and complete. Just today, as I was recording these thoughts, an interpretation emerged out of a remote association. Is it possible that the word Missouri is a play on words? We can imagine breaking Missouri into two parts: "miss" and "our I." Might we interpret the word miss as relating to feelings of loss and nostalgia? Might we interpret the phrase, "our I" as relating to the notion of a shared identity: the self and a mirror image? Also, might we imagine that the sense of loss in the dream was overdetermined? I was both physically lost in a place I had never visited before and I was also mourning the loss of something from my past: fragments of Self and Other. (I told my then treating psychiatrist, Alice E. Stone, M.D., about this dream in 2015. I remember telling her: "The only thing I can associate to is the killing of Michael Brown in Ferguson, Missouri, in 2014.")

Throughout the dream I kept hearing a song by Gustav Mahler, “I am lost to the world.” The theme of *being lost* is an important theme of the dream.

The following is the text of Mahler’s song, “I am lost to the world,” which figured in my dream:

*I am lost to the world
with which I used to waste so much time,
It has heard nothing from me for so long
that it may very well believe that I am dead!*

*It is of no consequence to me
Whether it thinks me dead;
I cannot deny it,
for I really am dead to the world.*

*I am dead to the world's tumult,
And I rest in a quiet realm!
I live alone in my heaven,
In my love and in my song!*

According to psychoanalyst Adam Phillips, fantasies or dreams about “being lost” can relate to the primal scene. In psychoanalysis the expression “primal scene” refers to the sight of sexual relations between the parents, as observed, constructed, or fantasized by a child and interpreted by the child as a scene of violence. The scene is not understood by the child, remaining enigmatic but at the same time provoking sexual excitement. Phillips says that fantasies or dreams about “being lost” (though a painful state) can be the lesser of two evils, where the alternative to being lost is being an intruder in a place where one is not supposed to be and risking punishment (such as, being in the parents’ bedroom).

Is there any reason why I would identify with Michael Brown, the young black man fatally shot by the police in Ferguson, Missouri, based on any shared experience? In fact, there is a point of correspondence between us based on something I experienced in the year 2002. The following is a contemporaneous report I wrote that features the theme of *intrusion*:

6-28-02 A strange and distressing incident happened yesterday afternoon (6/27) at about 3:55 PM – 4:00 PM at the Georgia Avenue/Petworth Metro Station. A Metro transit cop (white male) stopped me near the kiosk on the mezzanine above the track level. He asked me where I was coming from, where I was headed, whether I had anything on me he should know about – drugs, needles – He asked to see my arms to check for injection marks, asked if I use drugs or ever used drugs. I told him I was in the neighborhood to visit the mental health center (I had a consult with my psychologist, Dr. Shaffer). He asked me the address (I said 1125 Spring Road). He stated that there was a lot of drug trafficking in the neighborhood. His manner was mildly intimidating, and not at all friendly. The only reason I can see for the stop was that I was white in an overwhelmingly black/Hispanic neighborhood. I think it was racial profiling. What was his probable cause for the stop? At no time did he initiate physical contact. He declined to see my ID, which I offered.

The officer asked me: “Is there anything in your pants I need to know about.” I felt like giving him a sarcastic response: “Yeah, officer, my penis.” I decided it wouldn’t be a good idea to joke with the officer.

What were the events of the day September 29, 2015 that preceded my dream that evening?

I had had a consult with my primary care doctor, Dr. P—, who practiced at a clinic that provides healthcare services to the underserved community. This was my first consult with him. My previous primary care doctor,

Reggie Elliott, M.D. – who I had seen for about two years – had been transferred to another clinic. Dr. Elliott was a black physician. I liked Dr. Elliott and, at some level, I may have viewed Dr. P– as an interloper or intruder. I asked Dr. P– if he would prescribe testosterone. Three months earlier, in July 2015, I had asked Dr. Elliott in an email to consider prescribing testosterone. Apparently, this was something I had on my mind for some time. At my consult with Dr. P– I was curious about whether testosterone was administered orally or by injection. Dr. P– refused to prescribe testosterone or even test my testosterone level. He explained that testosterone therapy posed significant risk, including heart attack, and that he never prescribed testosterone to any of his patients. Did I feel thwarted or frustrated by Dr. P–’s refusal; did I feel he was failing to give me what I wanted? It is possible that I got a flu shot during this clinic visit – an injection – though I don’t recall now.

After meeting Dr. P– on September 29, 2015, I was curious about him. That evening I Googled him and learned that he was a native of New Orleans, that he had graduated with honors from medical school, and that he had earned a master’s degree in public health. There was an element of the uncanny in what I learned. At that time I was working on a novel that I called *The Emerald Archive*. In my notes for the novel dated February 17, 2015 – written seven months before I met Dr. P– – I had conceived a fictional character, a young medical doctor who grew up in the south, had graduated with honors from medical school, and who had an interest in public health (“infectious diseases and epidemiology”).

After my first consult with Dr. P– I regressed to a state of intense, primitive idealization of him. I felt as if I had found in Dr. P– a psychological twin.

The Theme of the Injection

When I was three years old I contracted scarlet fever, an infectious disease. My pediatrician, Joseph Bloom, M.D., diagnosed the illness during a house call. The doctor was “directly aware, too, of the origin of the infection,” which he attributed to my drinking spoiled milk from a baby bottle; my mother had indulged my taste for spoiled milk. Dr. Bloom scolded my parents: “Why is a three-year-old still drinking from a bottle? A three-year-old should not be drinking from a bottle.” The doctor told my mother to throw away the bottle and force me to drink from a cup. I surmise that Dr. Bloom gave me an injection of penicillin with a syringe.

I can recall the scene in my bedroom (one of my earliest memories): my embarrassment, nay, narcissistic mortification that the intruding doctor had discovered my secret attachment to my bottle – and my father, aroused to anger with my mother, using the doctor’s statements as ammunition to attack my mother’s parenting. To some degree, my illness took second stage at this moment to ongoing conflicts between my parents. Dr. Bloom explained that he was required to report my scarlet fever, deemed a serious public health concern, to the Philadelphia Department of Health. Thereafter, the Health Department quarantined our house, posting a notice on the front door: “No one other than family members may enter this premises.” The affair – the involvement of government authorities – was a cause of serious embarrassment to my parents.

Of psychoanalytic interest is the possibility that my baby bottle had served as a transitional object for me that I had invested with psychic importance. If so, I might have experienced loss of the bottle as traumatic, namely, the loss of a psychic fragment of myself. Then too, the doctor’s censure of me provoked a confrontation with reality – namely, forcing me

to recognize that my pleasurable (and fantasy-laden) activity was actually life-threatening – that undermined my illusions and may have caused an early injury to the self (narcissistic mortification). Like Goethe's Faust, my "beautiful world was destroyed" in an instant.

Note the issue of injection. I surmise that Dr. Bloom gave me an injection of penicillin by syringe to treat the scarlet fever infection. The police incident from June 2002 involved the issues of *wrongdoing* and *injections*. The police officer questioned me about my possible illegal drug use and he looked for evidence of drug injections in my arm. When I contracted scarlet fever at age three, the issues were "wrongdoing" (drinking from a baby bottle) and possible penicillin *injection*.

Also, I probably experienced Dr. Bloom in my bedroom as an intrusion on my private space—my bedroom. Dr. Bloom was the intruding doctor. Perhaps I thought: "Who is this intruder? What right does he have to invade my closeted realm and cause me this distress, embarrassing me in front of my parents and ordering me to give up my bottle (my transitional object?)"

Perhaps I projected a paternal (Oedipal) image onto Dr. Bloom. In my three-year-old mind, was Dr. Bloom not the intruder who violated my inner sanctum and exposed my secret attachment to my bottle and, further, interfered with my internal world of fantasy (by denying me my transitional object), just as my father was the intruder who violated my relationship with my mother? But then, was I not also the intruder on my parents' primal scene, at least in fantasy? Was I not the intruder who violated my parents' private (secret) relationship?

"Multiple and shifting identificatory positions can be discerned in primal scene configurations. Primal scene experiences and fantasies are viewed as

a blueprint for internalized object relationships.” Knafo, D. and Feiner, K. “The Primal Scene: Variations on a Theme.” We see the possibility at age three of multiple and shifting identifications as proposed by Knafo and Feiner: Dr. Bloom (intruder) = Oedipal Father (intruder) = self (intruder). (At my first consult with Dr. P— on September 29, 2015, did I view him at some level as the intruder who replaced my previous doctor, Reggie Elliott?).

An issue for inquiry is the extent to which my lifelong feelings of alienation – my sense of being *lost in the world* and of being an alien intruder in social situations – is invested with affect whose origins lie in primal scene fantasy. Naomi Morgenstern has spoken of “the anxiety and sense of alienation associated with primal scene.” See, Morgenstern, N., “The Primal Scene in the Public Domain: E.L. Doctorow’s ‘The Book of Daniel.’”

If my sense of alienation is invested with primal scene fantasy, is it not also possible, by extension, that my tendency to regress to intense primitive idealization of certain persons might also be related to primal scene fantasy in some way? That is a wild thought. But I associate to Toni Morrison's novel, *The Bluest Eye*. Keep in mind that primal scene fantasy is invested with violence and trauma. In Morrison's novel the traumatized protagonist, Pecola – who struggles with a shattered identity – “embodies the black individual's history of oppression and exclusion [like the child in primal scene fantasy who is excluded from the parents' bedroom?]. She suffers prolonged exposure to domestic and communal violence, which produces what Kai Erikson calls ‘psychic erosion’.” Ramirez, M.L., “The Theme of the Shattered Self in Toni Morrison’s *The Bluest Eye* and A Mercy.” Pecola creates an idealized “alter ego, Twin, to cope with trauma[,]” . . . “to defend [herself] against the dangers to [her] being that are the consequences of [her] failure to achieve a secure sense of [her] own identity.” *Id.*, quoting R.D. Laing. Pecola's sense of “I” is impaired and her fantasied, idealized double – a second “I,” which became for her, “our I” –

propitiates her psychological struggles. I note, incidentally, that Narendra Keval "propose[s] that *thwarting the other* links the racist scene to the psychoanalytic notion of the "primal scene, in which complex psychic issues are being worked out. Like fantasies of the primal scene, racist scenes also involve an intermingling of benign and malignant elements that contain racial and racist fantasies respectively, oscillating between a sense of curiosity and concern that accommodates the ethnic other and descent into a spiral of hatred and revenge." Keval, N., "Racist States of Mind: Understanding the Perversion of Curiosity and Concern."

There is an intimate connection between idealization and the sense of alienation: one can imagine that the alienated individual might idealize those few persons who mirror him, that is, those persons who, by virtue of their perceived selfsameness, do not arouse a sense of the alien in him, or, at a fantasy level, create an idealized twin that is capable of perfect empathy. *You and I are identical. My "I" is identical to your "I." Our "I's" are the same: fused and inalienable.* Twinlike representation of another person provides the illusion of being able to impersonate or transform oneself into the other and the other into the self. Coen, S.J. and Bradlow, P.A. "Twin Transference as a Compromise Formation." Finding oneself in another person obviates feelings of alienation. See Kottler, A. "Feeling at Home, Belonging, and Being Human: Kohut, Self Psychology, Twinship, and Alienation."

Melanie Klein considered twin fantasy to be ubiquitous, but especially intense in illness. Significantly, as it relates to me, Klein associated twin fantasy with the need for self-understanding and, by implication, to self-analysis. "The longing to understand oneself is also bound up with the need to be understood by the internalized good object. One expression of this longing is the universal phantasy of having a twin . . . This twin figure [] represents those un-understood and split off parts which the individual is longing to regain, in the hope of achieving wholeness and complete understanding; they are sometimes felt to be the ideal parts. At

other times the twin also represents an entirely reliable, in fact, idealized internal object." Klein, M., "On the Sense of Loneliness." Didier Anziu, too, linked the longing for self-understanding with the creation of an imaginary other (perhaps, a twin): "A self-analysis that is curative and creative requires at least two persons, one of whom is imaginary." Anziu, D., "Beckett: Self-Analysis and Creativity."

Be that as it may.

Permit me to revisit a dream I had in November 1992, days before Thanksgiving: a dream I called "The Dream of Greensboro.

The Dream of Greensboro

I had the following dream following the evening of November 24, 1992:

I find myself in Greensboro, North Carolina. I am in a residential section that appears to be deserted. The houses appear to be built on sand. There are sand dunes everywhere. Feelings of isolation and anxiety. Am aware that this is place where Jesse Raben, a former co-worker, is from. (Jesse Raben's father is a professor of Radiology at the University of North Carolina). I see a building that appears to be a school. The building's cornerstone has the inscription "1954." I note that the building's design suggests that the school was built much earlier than 1954; this strikes me as peculiar. The building has a tower.

[My birthday is December 23, 1953. When I calculate my age I always subtract "1954" from the current year. Apparently, the dream image of the school represents me.]

I am filled with feelings of awe, and imagine that Jesse Raben must have attended

this school. I want to leave the town. I am afraid to ask anyone where the train station is located lest I reveal that I am desperate to leave. ***I fear that questions will be raised concerning what I am doing in the town; I have the feeling that I am not supposed to be here and fear that others will discover my “transgression.*** Instead of asking where the train station is located, I ask where the business district is located, reasoning that the train station must be located somewhere in the business district. I think that if I can be directed to the business district, I will be able to find the train station on my own. The locale begins to resemble the business district in Moorestown, New Jersey, where my sister lives.

An event from earlier in the day appears to have been the proximate instigating event of the dream. As I wrote in my contemporaneous dream interpretation: “On the morning of Tuesday November 24, 1992, before a session with Dr. Suzanne M. Pitts, my then-treating psychiatrist at GW, I had walked out into the corridor adjacent to the office of Jerry M. Wiener, M.D. Dr. Wiener was at that time chairman of GW’s psychiatry department and a nationally-prominent psychiatrist who I admired. I had a feeling of awe when I saw him, but thought, ‘I’m intruding, I’m not supposed to be in this corridor; I have committed a transgression.’”

In this event I experienced conscious feelings of idealization mixed with a sense of wrongdoing – of having intruded on Dr. Wiener’s private space. I had had a contentious relationship with my psychiatrist, Dr. Pitts; my feelings about her were invested with fears of maternal engulfment. Perhaps, in my mind, Dr. Wiener was the distant but idealized father who, in my fantasy, offered rescue from the engulfing mother (Dr. Pitts). I had often spoken with Dr. Pitts about my preference for a male psychiatrist. I told her of my jealousy of Jeffrey Akman, M.D., a young male psychiatrist in the psychiatry department who appeared to be Dr. Wiener’s protégé. Jesse Raben, the coworker I dreamed about, was also a distant but idealized figure (who seems to have been invested with my

rescue fantasy; when we worked together I associated the name Raben with the rescuer of the Biblical Joseph (the famous dream interpreter), Reuben, Joseph's older brother).

Note that as a small child, I might have viewed my going off to school as offering freedom or rescue *from* my engulfing mother. Here, I would be the *passive party* in need of rescue from mother. In the Greensboro dream, perhaps, Raben = idealized father as rescue figure = school (with the phallic tower) as idealized (male) rescue figure = me.

Then again, the theme of rescue is related to the primal scene, where the child feels the need to rescue mother. In the primal scene fantasy, I would be the *active party*, rescuing mother. Salman Akhtar writes: "While children of both sexes feel it, the sense that one's mother has been co-opted, indeed invaded, by the father is especially intense in the case of a boy. Exposure to the primal scene (in actuality or imagination), in the setting of immature ego-functions, and anger at the parents for such 'betrayal' further fuels the child's rage. By the mechanism of compartmentalization, mother's active sexual participation is negated and the father is seen as a violent invader of the mother's pristine body. *The need to rescue mother is powerfully felt.*" Akhtar, S. *Mind, Culture, and Global Unrest: Psychoanalytic Reflections*.

I note parenthetically that, indeed, in another dream that dates from June 15, 1993 I imagined that I was *Raben's* rescuer, possibly suggesting an aspect of twinship: the transformation of self into other and other into self. In the Greensboro dream perhaps I viewed Raben as my rescuer; while in the dream below I was Raben's rescuer. See Coen and Bradlow, above:

The Dream of Murder in the Lobby

I am in the lobby of an unidentified building. The lobby is crowded with people, all milling about. Present in the lobby is a former co-worker at [the law firm where I worked with] Raben. An unidentified individual enters the room, pulls out a gun, and shoots Raben, then walks out. Raben falls to the floor; he lies prostate, unconscious, and bleeding profusely. I have the feeling that everyone in the room knows Raben, but does nothing. They seem to ignore what has just occurred. I feel I have a special mission to save Raben. I telephone an ambulance. I am overcome with a feeling of futility. I think that even if a doctor arrives in a very brief time, Raben will have bled to death before he can be treated.

Let us remember that the role of the early father, according to psychoanalyst Peter Blos, is that of a rescuer or savior at the time when the small child normally makes his determined effort to gain independence from the first and exclusive care-taking person, usually the mother. At this juncture the father attachment offers an indispensable and irreplaceable help to the infant's effort to resist the regressive pull to total maternal dependency, thus enabling the child to give free rein to the innate strivings of physiological and psychological progression, i.e., maturation. Blos, P. "Freud and the Father Complex."

This takes us back to Kohut's psychoanalytic case of Mr. U. My psychology parallels Kohut's patient Mr. U who, turning away from the unreliable empathy of his mother, tried to gain confirmation of his self through an idealizing relationship with his father. The self-absorbed father, however, unable to respond appropriately, rebuffed his son's attempt to be close to him, depriving him of the needed merger with the idealized self-object and, hence, of the opportunity for gradually recognizing the self-object's shortcomings. Kohut, H., *The Restoration of the Self*.

A recurring pattern in my adult interpersonal relations is my need for an idealized male – or other object – as a defense against fears of maternal engulfment. The Greensboro dream might relate back to my childhood sense that elementary school attendance represented freedom from my mother. My mother used to tell a story about my first day of kindergarten. She walked me to school, and when we arrived at the threshold of the schoolyard, I turned to her and said (at age 4 1/2): “Go home, mommy, I don’t need you anymore!”

Significant in the present context is the extent to which my imagined intrusion into the city of Greensboro in the dream was invested with primal scene fantasy: In the dream I had intruded on an idealized figure’s private space.

An association: When I was thirty-three years old I was employed as a paralegal in the computer department at a law firm where I was assigned for a brief time to a special project for an attorney. I was allowed to work temporarily in my supervisor’s office suite in an office adjacent to hers. At one point my supervisor, Sheryl Ferguson, had an angry confrontation with said attorney outside my office door: “How long is this project going to go on? There’s already been a security breach because of him (meaning *me*). I want him out of here!” I had stolen confidential information: the computer password of the department’s consultant, Bob Ferguson. I was the intruder who had come into possession of confidential information, like the child who fantasizes spying on his parents in their bedroom, that is, the primal scene fantasy. The name Ferguson is identical to the name of the city in Missouri where Michael Brown was killed in a confrontation with police, Ferguson, Missouri.

I associated The Dream of the Intruding Doctor with my former primary

care doctor, Dr. P—, though he was not present in the manifest dream. Circumstantial evidence that the dream was in fact related to my repressed thoughts about Dr. P— comes from the following later dream, from March 8, 2019, in which Dr. P— is a central figure:

The Dream of the Family Gathering

I am at the house where I grew up. There is a large family gathering at which my parents are present. Dr. P— is there. I am happy to see him, but I don't want to look too excited. My family treats him like a beloved son. My family ignores me; they appear to shun me. All their attention is focused on Dr. P—. Dr. P— ignores me also; he won't make eye contact. He seems happy and profoundly content. I have strong feelings of sadness and distress about Dr. P— ignoring me and my family ignoring me. I feel that Dr. P— has usurped me. I feel like an outsider in my own family. The family leads him into the kitchen, while I gaze on.

Thoughts:

My view of Dr. P— as my usurper in this dream seems connected to my role as an intruder in the earlier Dream of the Intruding Doctor, someone who did not belong in Missouri: the outsider, alien, or interloper. In The Dream of the Family Gathering, Dr. P— is a “welcome outsider” to my parents while to me he is an intruder, which parallels the biographical incident from age three, discussed earlier, when I came down with scarlet fever. My pediatrician (Dr. Bloom) was a “welcome outsider” to my parents and to me, perhaps, an intruder.

The dream suggests that I see Dr. P— as the successful son my parents never had. He is my father's “best-loved, ideal son.” See, Blos, P. “The Genealogy of the Ego Ideal.” I suppose I am deeply envious of him; I feel he has the accomplishments and traits that rightly belong to me, but that

in fact belong to him.

The figure of Dr. P— in this dream reminds me of the so-called “happy mortal” described by Goethe in his novel, *The Sorrows of Young Werther*: “We often feel that we lack something, and seem to see that very quality in someone else, promptly attributing all our own qualities to him too, and a kind of ideal contentment as well. And so the happy mortal is a model of complete perfection—which we have ourselves created.”

I see superego issues. Dr. P— is my ego ideal. The distress I feel in the dream is the disparity between my ego and my own ego ideal. We might say that my feelings in this dream relate to a state of “self-estrangement” in which I sense a discrepancy between my ideal self and my actual self-image. See, TenHouten, W., *Alienation and Affect*.

I think about a biographical incident from Sunday May 18, 1969. I was 15 years old. My sister and brother-in-law got married the previous Sunday, on May 11. On the night of their wedding, they flew to Miami Beach, Florida for their honeymoon. A week later, on the 18th, when they returned, my parents and I picked them up at the airport. They returned to my parents’ house. My uncle Louie and his wife Reggie were there. My mother happened to have a bottle of champagne. We drank a glass of champagne. My sister and brother-in-law had purchased a gift for me, a men’s jewelry box. In retrospect, the jewelry box reminds me of the theme of the three caskets from Shakespeare’s play, *The Merchant of Venice*. In that play the fair and wise Portia is bound at her father’s bidding to take as her husband only that one of her suitors who chooses the right casket from among the three before him. The three caskets are of gold, silver and lead: the right casket is the one that contains her portrait. Two suitors have already departed unsuccessful: they have chosen gold and silver. Bassanio, the third decides in favor of lead; thereby he wins the bride, whose affection was already his before the trial of fortune. The suitor’s choice in *The Merchant of Venice* parallels my dream in that my

parents appear to have chosen Dr. P— over me. It's as if my parents were thinking, "Now that we have Dr. P—, we don't need Gary anymore." In some sense I was the loser in a competition, which suggests an Oedipal theme. (Incidentally, note the curious parallel to my earlier anecdote: "My mother used to tell a story about my first day of kindergarten. She walked me to school, and when we arrived at the threshold of the schoolyard, I turned to her and said (at age 4½): 'Go home, mommy, I don't need you anymore!' For me, perhaps attainment of the idealized object, whether Dr. P— in the dream or school in childhood, obviated the need for the devalued object, namely, me in the dream or my mother in childhood.)

As I see it, The Dream of the Family Gathering relates to introjective concerns, not anaclitic concerns. People say about me, "He's very lonely and he wants a friend. That's why he is obsessed with his former primary care doctor." No. Those are interpersonal, anaclitic concerns.

In this dream I am failing to live up to my parents' (and my own) expectations: Patients with introjective disorders are plagued by feelings of guilt, self-criticism, inferiority, and worthlessness. They tend to be more perfectionistic, duty-bound, and competitive individuals, who often feel like they have to compensate for failing to live up to their own and the perceived expectations of others. The basic wish is to be acknowledged, respected, and admired. That's exactly what my parents are doing in the dream; they are giving Dr. P— acknowledgement, respect and admiration – all the things being denied me in the dream. Individuals with a self-critical personality style may be more vulnerable to depressive states in response to disruptions in self-definition and personal achievement. These individuals may experience "introjective" depressive states around feelings of failure and guilt centered on self-worth.

A biographical incident comes to mind. When I was 32 years old I

worked as a paralegal at a large law firm. A new employee named Craig Dye began employment. I had formed a strong dislike of him before I met him, though we later became friends. *Another employee had said to me weeks before, “They’re hiring a new guy. He’s really good. They might just decide they don’t need you anymore.”* When I met Craig I thought, “So you’re the guy who’s going to take my job.” During the following months my working relationship with Craig was one of rivalry. Craig and I had many similar characteristics. When there was competition for a particular assignment, or if I had to submit work in competition with that of peers, I confidently assumed I would win. Craig and I were both intelligent and gifted, and that helped us to live up even to overweening pretensions. Although generally good-natured and even “humble” in manner, we both had many arrogant traits. Compounding the hostility between Craig and me was the fact that our supervisor was an attractive young woman. That is, the relationship between Craig and me vis-a-vis a female authority carried an implicit plea, not unlike the plea of the three suitors to Portia in *The Merchant of Venice*: “Choose one of us. Is it to be he or I?”

Additional Thoughts:

I woke up on the morning of April 6, 2019 thinking of events that had transpired exactly thirty years earlier, on April 6, 1989. At that time I worked as a paralegal at the law firm of Akin, Gump, Strauss, Hauer & Feld, which was founded by the eminent attorney, Robert S. Strauss. The firm had arranged a “Breakfast with Bob Strauss.” About sixty of the firm’s paralegals gathered to hear Bob Strauss speak and answer questions. Strauss and others sat at the head table at the front of the large fifth floor conference room. Another paralegal, Jesse Raben was seated at the head table, which sparked my jealousy. I thought, “How did Raben get to sit at the head table with Strauss and the important people like law partner, Earl Segal? How did Raben get to be so important – he’s just a

paralegal like me!” I saw Raben as my usurper, perhaps — or my rival.

It may be that at some level I registered an association to my sister’s wedding when I was 15 years old, when I sat at the head table of the wedding ballroom as best man together with other members of my family. At my sister’s wedding I remember feeling ignored by my family; all their attention was focused on my sister. I remember that when we had completed our meal, I was still sitting alone at the head table, smoking a cigar. My family had left the head table by that time and had started mingling with the guests. As I sat alone, the wedding photographer approached me. He said: “There are a lot of girls here. Why don’t you talk to them instead of sitting alone smoking a cigar?” I took his advice and proceeded to chat with my sister’s female friends. A week later, when my sister and brother-in-law returned from their honeymoon in Miami Beach, we had a small family gathering where my mother opened a bottle of champagne she had on hand.

Later in the morning of April 6, 2019 I listened to the second act of Strauss’s *Arabella*. The second act of the opera is one of my favorite Strauss pieces. I never listen to Acts 1 or 3; I find them tedious. I have always loved Act 2. The action takes place in a ballroom at a hotel in Vienna in the 1860s. Early in the act Mandryka proposes marriage to Arabella, who accepts. Mandryka orders champagne for the guests at the ball, “*Moët et Chandon, medium dry.*”

In a pivotal moment in the opera, Arabella accepts Mandryka’s marriage proposal, and pledges her eternal love — “You will be my lord” . . . “from here to eternity” (“*auf zeit und ewigkeit*”).

Later in the act Arabella meets up with her three suitors Elemer, Dominick, and Lamoral, and discards them, telling them she will never

see them again. These events parallel the theme of the three caskets in *The Merchant of Venice*, where Portia rejects two of her suitors in favor of Bassanio. Arabella's father, Mr. Waldner, sits at a table at the ball playing cards with his friends — like Bob Strauss playing cards with his poker buddies, who, incidentally, included the late Chief Justice William Rehnquist, appeals court Judge David Sentelle, and the late Martin Feinstein, onetime director of the Washington National Opera.

These associations highlight the themes of jealousy, rivalry, usurpation, losing in competition, and feelings of contemptible anonymity at a gathering. These are Oedipal themes, or introjective concerns.

I am reminded of the observations of British sociologist Yiannis Gabriel who points out the biological imperative of what we might term Oedipal aggrandizement: the male's efforts to distinguish himself from amorous rivals in order to win the ideal mate. "Like collectivism, individualism can be traced to the dissolution of the Oedipus complex and the institution of the superego. Both collectivism and individualism are attempts to placate the superego, the former through submission to the social order, the latter through distinction, excellence and achievement. Conformity alone cannot satisfy the superego — after all it is not by being one of the crowd that the boy will win the ultimate prize, the woman of his dreams; nor does being part of the crowd win for the girl the 'happy-ever-after' life of her dreams. One looks in vain for fairy tales about lemmings working together to accomplish collective tasks. Achievement, distinction and excellence are what grip the child's imagination, which idealizes the heroes and heroines of fairy tales and casts him or herself in the starring role. It is by slaying dragons, answering riddles, and accomplishing the impossible that the child achieves the fulfillment of the promise which concluded his or her Oedipal drama." *Organizations in Depth: The Psychoanalysis of Organizations*.

At the workplace “Breakfast with Bob Strauss” I must have felt I had been cast with the lemmings – I was part of a collective of equals, just one of the crowd, without distinction, a humiliated state of contemptible anonymity, seated with fellow paralegals at indistinguishable tables. Raben had achieved distinction with an envied seated position next to firm founder, Bob Strauss – the all-powerful father figure of the organization. Raben had assured his identification with the primal father. Raben had set himself apart from fellow paralegals, the “band of brothers,” sons of the primal father.

In the Dream of the Family Gathering, Dr. P— was cast in the starring role, as he had been at his own wedding where he had won the girl of his dreams. On the evening of the day I met Dr. P— (September 29, 2015) (hours before I dreamed about finding myself in Missouri) I had discovered on the Internet a lengthy newspaper article about him and his wife; the couple had gotten married the previous year in an extravagant wedding in the Caribbean.

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What's done cannot be undone.—

—*Shakespeare, Macbeth, Act V, Scene 1.*

It is not the literal past that rules us, save, possibly, in a biological sense. It is images of the past. These are often as highly structured and selective as myths. Images and symbolic constructs of the past are imprinted, almost in the manner of genetic information, on our sensibility. Each new historical era mirrors itself in the picture and active mythology of its past.

—*George Steiner, In Bluebeard's Castle.*

There is no such thing as moral phenomena, but only a moral interpretation of phenomena.

—*Friedrich Nietzsche, Beyond Good and Evil.*

He will know the sounds of madness . . . and make them seem like music.

—*George Steiner, The Portage to San Cristobal of A.H.*

It is possible you are the consciousness of your unhappy family, its bird sent flying through the purgatorial flame.

—*T.S. Eliot, The Family Reunion*

I gave my therapist a copy of the dream interpretation I titled: “The Dream of the Intruding Doctor.”

I discussed the dream interpretation at length with my therapist. I talked about my feelings of alienation, idealization, and my feeling like an intruder. I talked about my pediatrician who treated a childhood illness.

I reported the following childhood memory from age three:

When I was three years old I contracted scarlet fever, an infectious disease. My pediatrician, Joseph Bloom, M.D., diagnosed the illness during a house call. The doctor was "directly aware, too, of the origin of the infection," which he attributed to my drinking spoiled milk from a baby bottle; my mother had indulged my taste for spoiled milk. Dr. Bloom scolded my parents: "Why is a three-year-old still drinking from a bottle? A three-year-old should not be drinking from a bottle." The doctor told my mother to throw away the bottle and force me to drink from a cup. I surmise that Dr. Bloom gave me an injection of penicillin with a syringe.

I can recall the scene in my bedroom (one of my earliest memories): my embarrassment, nay, narcissistic mortification that the intruding doctor had discovered my secret attachment to my bottle – and my father, aroused to anger with my mother, using the doctor's statements as ammunition to attack my mother's parenting. To some degree, my illness took second stage at this moment to ongoing conflicts between my parents. Dr. Bloom explained that he was required to report my scarlet fever, deemed a serious public health concern, to the Philadelphia Department of Health. Thereafter, the Health Department quarantined our house, posting a notice on the front door: "No one other than family members may enter this premises." The affair – the involvement of government authorities – was a cause of serious embarrassment to my parents.

Of psychoanalytic interest is the possibility that my baby bottle had served as a transitional object for me that I had invested with psychic importance. If so, I might have experienced loss of the bottle as traumatic, namely, the loss of a psychic fragment of myself. Then too, the doctor's censure of me provoked a confrontation with reality – namely, forcing me to recognize that my pleasurable (and fantasy-laden) activity was actually life-threatening – that undermined my illusions and may have caused an early injury to the self (narcissistic mortification). Like Goethe's Faust, my "beautiful world was destroyed" in an instant.

I offered the following reconstruction of my possible perception at age three of my pediatrician as an "intruder":

I probably experienced Dr. Bloom in my bedroom as an intrusion on my private space—my bedroom. Dr. Bloom was the intruding doctor. Perhaps I thought: “Who is this intruder? What right does he have to invade my closeted realm and cause me this distress, embarrassing me in front of my parents and ordering me to give up my bottle (my transitional object?)”

Late in the session the therapist offered the following opinion about this childhood memory that countered my present reconstruction of the doctor as an intruder:

“Maybe your doctor was your savior. Maybe he saved your life.”

I sensed that the therapist processed my report in the following way: “You say your doctor took away your bottle and caused you harm. You didn’t like what he did. You think your doctor was a bad guy. But maybe your doctor was a good guy.” She seemed to attach a moral gloss to my childhood memory, as if my report centered on my evaluation of the moral equities of the pediatrician.

What I suspect is that, in fact, this childhood incident was terrifying for me and that those feelings of terror were traumatic in the moment I experienced them — and that I registered the event in my unconscious memory as traumatic. If I view the doctor as a good actor (and I never said I thought he was a bad actor!) how would that undo those childhood feelings of terror and my possible registration of the event as traumatic? If I adopted a conscious view of my pediatrician as my savior, how would that undo the unconscious fantasies about the incident that that terror might have mobilized?

I did some research. There's a body of literature that discusses so-called "medical trauma." It sometimes happens that a child will register as traumatic medical procedures he underwent, despite the objective fact that the treatment was beneficial and the aims of the treatment providers were beneficent. How will an adult who struggles with medical trauma from childhood benefit from adopting a conscious view of his treatment providers as his saviors? Any reasonable and mature adult will already know at a conscious level that the doctors who treated him as a child were his benefactors.

One article states: "Medical trauma, while not a common term in the lexicon of the health professions, is a phenomenon that deserves the attention of mental and physical healthcare providers. Trauma experienced as a result of medical procedures, illnesses, and hospital stays can have lasting effects. Those who experience medical trauma can develop clinically significant reactions such as PTSD, anxiety, depression, complicated grief, and somatic complaints. In addition to clinical disorders, secondary crises—including developmental, physical, existential, relational, occupational, spiritual, and of self—can lead people to seek counseling for ongoing support, growth, and healing. While counselors are central in treating the aftereffects of medical trauma and helping clients experience post-traumatic growth, the authors suggest the importance of mental health practitioners in the prevention and assessment of medical trauma within an integrated health paradigm." Hall, M.F. and Hall, S.E., "When Treatment Becomes Trauma: Defining, Preventing, and Transforming Medical Trauma."

What were the traumatic aspects of the scarlet fever incident? I suspect that in that moment I was overwhelmed with feelings of *terror*. Think about it. I was a three-year-old child. I was doing something pleasurable – drinking from my bottle. A strange doctor comes into my bedroom. He gets angry. My parents start arguing. The doctor takes away something I valued that was given to me by my mother for my supposed benefit. I am

depicted as bad because I had been doing something that my mother approved of. I am given an injection. Imagine the confusion and terror a three-year-old would experience in that situation. The therapist's intervention – namely, that I should view my pediatrician as my savior – occurred without regard to the complexity of the situation; the roles or relationships of the parties involved; my affective (or traumatic) response to the event; and my unconscious processing of the event.

But there is more than this.

First, the loss of the bottle (a possible transitional object) might have triggered feelings of loss and mourning in me. Winnicott wrote a case study about a boy who had lost his transitional object, a small woolen toy called the Niffler, under traumatic circumstances. The boy thereafter struggled with feelings of loss and mourning. See, Winnicott, D.W. "The Niffler."

Then too, I suspect that the incident aroused feelings of narcissistic mortification. Feelings of terror underlie narcissistic mortification. The term has been defined as "the primitive terror of self-dissolution, triggered by the sudden exposure of one's sense of a defective self . . . it is death by embarrassment." The experience of narcissistic mortification in childhood can lead to injuries to the ego/self that can lead to narcissistic disturbance in adulthood.

When narcissistic mortification is experienced for the first time, it may be defined as a sudden loss of control over external or internal reality, or both. This produces strong emotions of terror.

The psychological sensations described are feeling shocked, exposed, and humiliated. Descriptions of this experience can be, for example: "It feels like I won't survive" and "I have the absolute conviction that he or she hates me and it's my fault." These sensations are always followed by

shock, although they may have happened on various occasions, they also prompt the need for the individual suffering to do something both internally and externally, to effect a positive self-image in the eyes of their narcissistic object. Narcissistic mortification is extreme in its intensity, global nature, and its lack of perspective, causing the anxiety associated with it to become *traumatic*.

Additionally, the therapist's failure to consider the traumatic aspects of the incident – and her exclusive concern with the moral equities of the pediatrician – foreclosed her consideration of how the incident might play a role in my adult life. Psychoanalyst Harold Blum has shown, for example, that childhood trauma can be transformed and temporally-displaced by the mind such that the underlying traumatic source of an adult's psychological preoccupations is masked. Through the disguise of affective reversal of childhood trauma and associated unconscious conflicts, aspects of the original trauma might appear in the adult as, say, *idealization* rather than obvious traumatic sequelae. Cf. Blum, H.P., "The Creative Transformation of Trauma: Marcel Proust's *In Search of Lost Time*." One might legitimately speculate about the ways in which childhood medical trauma might perhaps lead to an adult individual's idealization of his treating physicians. Might my idealized obsessive preoccupation in adulthood with certain of my treating physicians, such as, Stanley R. Palombo, M.D., Laurence C. Sack, M.D. and Dr. P – be rooted in such a psychic transformation of childhood medical trauma? Keep in mind that idealization can serve as a defense against unconscious feelings of terror. Idealization can derive from the child's need to believe that caretakers, parents, medical doctors, or others can protect one from dangers in life. Children are frightened to confront the realities of hostility, illness, mortality, and other terrors for the first time, and idealization of the caretakers protects them against overwhelming fear and allows them to feel protected, cushioned from too severe a blow from reality. Anonymous, "What Are Defense Mechanisms Anyway? Primary Defense Processes."

INTRUDERS, RESCUERS, AND THE PROBLEM OF GUILT

It would be useful at this point to return to my written summary of the therapy session I had on August 21, 2018. I opened that session by talking about my sense of myself as an alien or an intruder in my family. I reported that I felt growing up that my parents and sister viewed the period before I was born as a kind of paradise. With my arrival, six years after the birth of my sister, my only sibling, the family faced new financial pressures and a threat to a stable triangle that featured a mother, father and idealized daughter: a narcissistic configuration involving relationships of “extreme intensity” as seen in dysfunctional families. See Brodsky, W. “On the Dynamics of Narcissism. I. Externalization and Early Ego Development.”

At that earlier session, the therapist offered an opinion based on CBT reframing. She suggested that, as a matter of fact, the family might not have been a paradise, that there was no objective evidence I was an intruder, and that I did not destroy anything. Of course, the issue is not simply the objective facts of my family’s circumstances, but unconscious factors underlying my perceptions and my family’s perceptions. Could the family myth, or phantasy, have been that I was an *intruder* who “destroyed their beautiful world?” How would their unconscious psychic reality have affected their interaction with me? Also, what is the source and psychic importance of my deeply-rooted sense of myself as an alien: “everywhere an intruder, never welcomed.”

I am struck by the parallels between the August 21 session and the present November 6 session. At the August 21 session, I reported that I viewed myself as the intruder who destroyed my parents’ “beautiful world” that had prevailed for the six years before I was born. I made a temporal reference, stating: “So, yeah, it was as if suddenly I appeared and overnight, things changed for my parents and sister.” At that session I

depicted myself as the active party, the intruder; my family was the passive party whose world I destroyed.

At the November 6 session, talking about the scarlet fever incident in my bedroom at age three, I reported that it was my pediatrician who was the *intruder* who destroyed my beautiful world, that is, he destroyed my relationship with my bottle, a possible transitional object invested by me with psychic importance. At the November 6 session it was *I* who was the passive party whose world was destroyed by the intruding doctor, the active party. (A patient's struggles to turn passive into active can relate to feelings of powerlessness and helplessness associated with trauma. See, e.g., Corradi, R.B., "Turning Passive into Active: a Building Block of Ego and Fundamental Mechanism of Defense.") I made a temporal reference, stating, "in an instant my world was destroyed." I talked about the onrush of events that might have seemed to me to occur with terrifying rapidity, "like a thief in the night": the doctor's anger, my parents' anger, the sudden perception of me as bad, the loss of my transitional object and the associated rupture of my inner world of fantasy – the penicillin injection. See, e.g., Gallagher, S. "How To Make Injections Less Traumatic For Your Child."

What is the psychic significance of the parallels between the therapy session on August 21 and that on November 6? Perhaps that is an important question.

The therapist's observation that my doctor was not *an intruder*, but, in fact, my *savior* who cured me of a serious illness prompted me to think about the connection between the roles of *intruder* and *rescuer*. Both the intruder and the rescuer can be seen to breach a boundary – either physical, situational, or psychological – to effect an outcome. The intruder breaches a boundary to cause harm. The rescuer breaches a boundary – he enters a situation – to bring about positive change. Might we say that the intruder is the polar opposite of the rescuer, and therefore

unconscious fantasies about these roles are susceptible to simultaneous mutual negation (and not present in alternating sequence as in conscious ambivalence). Is it possible that I formed the unconscious sense of my doctor at age three as both an *intruder* and a *rescuer* (savior)? Might that perception of external reality have played on a pre-existing fantasy system rooted in my inner psychic reality, namely, my perceived role designation in my family as both an *intruder* and *rescuer*, or savior, of my family? The psychoanalyst Phyllis Greenacre commented on the fact that whenever a traumatic experience was associated with an underlying fantasy, the fixation on the trauma is more persistent than in cases where the trauma was bland and incidental. One wonders where these questions lead us. Blos, P., "Character Formation in Adolescence."

We can think about how the dual *intruder/rescuer* role in a dysfunctional family relates to the problem of scapegoating and guilt – as embodied in the so-called identified patient.

Identified patient is a term used in a clinical setting to describe the person in a dysfunctional family who has been unconsciously selected to act out the family's inner conflicts as a diversion. This person, often a child, is "the split-off carrier of a breakdown in the entire family system," which may be a transgenerational disturbance or trauma.

The dysfunctional family (unconsciously) allocates particular functions to the identified patient in order to have its covert emotional needs met. Projective identification has been singled out as operating at an unconscious level in such families. Role lock – confirming mutual suction into complementary roles, such as victim and abuser – is ensured by the intermeshing of projective identifications of family members. The identified patient is manipulated to play a part, no matter how difficult to recognize, in the family's phantasy. The identified patient will have no insight into his assigned role, he will have a sense of experiencing strong feelings, and at the same time a belief that their existence is quite

adequately justified by the objective situation.

The psychodynamics of the identified patient comprise an unconscious pattern of behavior whereby an excess of painful feelings in a family lead to one member being identified as the cause of all the difficulties – a scapegoating of the identified patient. The identified patient both conceals and reveals a family's secret agendas.

In a family in which the members have difficulty in dealing with emotions such as anger, hostility, and guilt, one way of dealing with them which would substantially lessen their impact would be to "sweep them under the rug" or to channel them via the mechanism of scapegoating. In essence, then, scapegoating may usefully be seen as a kind of escape which is sometimes resorted to when the family finds itself unable to deal with tensions in more constructive ways. Scapegoating can be seen as a kind of motivated activity by family members in that it aids in the avoidance of dangerous or potentially dangerous conflicts. Kolb, S. "Some Communication Patterns Observed in Families Using an Identified Patient as a Scapegoat."

The family scapegoat plays a positive role in preserving the balance of the family system. In the dysfunctional family, the threat of conflict or aggression in the marriage, which would also threaten the survival of the system, is projected onto a child who "owns" the projection while returning the spousal subsystem to a calmer level. In assessing a clinical family, most family therapists would identify a central triangle, typically between parents and a child, which serves to balance the entire system. Everett, C.A. and Volgy, S.S. "Borderline Disorders: Family Assessment and Treatment."

We can see these dynamics operating to some extent when I was three years old. When my pediatrician told my parents that I had scarlet fever and reported the cause of the illness, my parents started to argue about

me; I became the problem. I was used as a diversion into which my parents could channel their aggression. It was *I* who was the spoiled child. My sister and brother-in-law repeated these dynamics in their relationship with my younger niece, who plaintively said to me at age 12: “They say I am a monster child. I am *not* a monster child.” My younger niece was sent off to a psychoanalyst for three-time-per-week analysis. My sister and brother-in-law meanwhile blithely carried on as if they had the perfect marriage.

The identified patient has yet another function. He might serve as the “emissary” of the family to the wider world; his actions can be seen as a coded cry for help by the individual on his parents’ behalf. The scapegoat will see himself as the family’s *savior* whose duty it is to get help.
Robertson, G. “The Identified Patient.” As such there may be an element of altruism in the identified patient’s behavior – playing sick to obtain help for his family.

One wonders about how, perhaps, my life-long preoccupation with psychotherapy is grounded in my sense of myself as an emissary for my family. Is my prolonged therapy – the repeated telling of my story – and my obsessive writing about my family driven by an unconscious sense of myself as someone chosen – like the so-called “designated survivor” of the Holocaust – to bear witness to the tragedy of my family? In the Holocaust it was the duty of the designated survivor to stay alive, no matter what that might entail, to tell the story of his destroyed community to outsiders; he bore the duty of witnessing.

As so eloquently described by T.S. Eliot: “It is possible you are the consciousness of your unhappy family, its bird sent flying through the purgatorial flame.”

One needs to inquire into the role of guilt resistance in my failure to improve in psychotherapy. Resistance can be a way of avoiding the

unconscious guilt associated with moving on; moving on would entail leaving the family behind. A patient who uses his difficulties to obtain fantasized redemption for others may unconsciously feel that he would have to grapple with guilt if he were free of his symptoms. Cabaniss, D.L. *Psychodynamic Psychotherapy: A Clinical Manual*.

The British therapist Sebastian Kraemer has important thoughts about the dual role of the scapegoated child as both *intruder* (scapegoat) and *rescuer* (savior) in the dysfunctional family:

Kraemer writes: "What inspired me about the work of the Milan group was the notion of sacrifice. Instead of having some mysterious illness or just being very wicked, the adolescent [identified patient] is seen as a kind of desperate *savior* of the family. I often invoke the role of Jesus Christ in this context because he also suffered in order to save. The difference is that the adolescent's efforts are neither recognized by anyone, nor particularly effective. The Milan method in its original form saw the identified patient, who was most often an adolescent with severe behavioral disturbance, such as anorexia nervosa or psychotic symptoms, as someone trying desperately to rescue one or both of the parents from their pain. The problems of the parents were the familiar ones – marital, psychiatric or even medical. Furthermore, this adolescent had always had a specially close relationship with the parent in question, usually the mother. To most observers she would indeed be regarded as in need of help in her own right. She was depressed, or suffered from chronic psychosomatic problems. This is typical of the family of anorexic adolescents and others who damage themselves slowly and menacingly. It also occurs in the families of some psychotic adolescents. In such families the parents commonly stay together, however unhappy they may be.

One aspect of the positive connotation consists in the reframing of the adolescent's disturbance as something which is meant to be useful.

Instead of saying that the patient is ill and has symptoms which have to be removed, the therapist identifies them as having a function, which up to now no one has been aware of. In effect this is an interpretation of an unconscious fantasy, but the language of family therapy did not recognize such a phenomenon, a matter to which I return later. The function, or fantasy, is one of sacrifice and of rescue. 'I will suffer in order to save you, my suffering parent'.

The family therapeutic interpretation of the young person's symptoms is that he or she is trying to make something, or someone, better. This often turns out to be an attempt, still unconscious, to make up for the deficiencies of one of the grandparents. In effect, the family tree has been turned upside down. Because of their special position in the family, these young patients are enrolled as guardian of one or both parents. They become full-time resident family therapists. It might be the mother who has been deprived in her own childhood. Now, having married someone just like her mother, she looks to one of her children to make up for what was missing. Any young person is capable of volunteering for the part, but in these cases the urgent wish to make mummy better has taken over completely, and the poor child has given up any other kind of ambition such as learning to grow up." Kraemer, S. *The Promise of Family Therapy*.

I suspect the recognized role of identified patient dynamics in the families of anorexic patients is significant for me. Some therapists emphasize the part of unconscious guilt in the genesis of anorexia nervosa. It can hardly be inconsequential that the underlying matter that caused my scarlet fever was the issue of child feeding, an activity that involved both my mother's and my unconscious fantasies surrounding eating and being fed. Keep in mind, as I have pointed out elsewhere, my mother's impoverished family of origin struggled with near starvation, subsisting at times on meals of rice boiled in milk. Yes, *milk!* Then too, there is a possible issue of loss and mourning for my mother. My mother's father died when she was

three years old (of an infectious disease) – the same age I was when I contracted scarlet fever.

The psychoanalyst Michael Friedman sees guilt-inducing behaviors by parents as central to the genesis of anorexia nervosa. Of course, guilt-inducing behaviors are also central to scapegoating, a disturbed role assignment in which a child is seen by parents as both an *intruder* and *rescuer*, or savior.

Friedman writes: "Modell described a kind of guilt based on the belief that taking is at someone else's expense: 'There is a common fantasy that is observed in psychoanalysis, that is: love is a concrete substance in limited supply within a given family—as if all of the family are obtaining nourishment from a closed container. The subsequent belief is: if one has something good, it is at the expense of someone else being deprived.' This type of guilt, termed depletion guilt, is based on the belief that one's own welfare is at the expense of another's—that one is a survivor at someone else's expense. It is a form of survivor guilt, which may take many forms, each related to a belief about the way in which the pursuit of normal developmental goals will harm significant others."

Often parents contribute to these beliefs by conveying to their child, through praise or blame, an inaccurate sense of his or her ability to bring them happiness. These beliefs are encouraged by parents who convey to their children an inaccurate sense of their ability to affect the quality of their parents' lives. Some parents convey a sense of fragility which the child perceives unconsciously. Some individuals are burdened by unconscious guilt over hurting somewhat fragile mothers by depleting them. Friedman, M. "Survivor Guilt in the Pathogenesis of Anorexia Nervosa."

THE THERAPIST'S ONE-DIMENSIONAL PERSPECTIVE AND DENIAL OF AFFECTS

The therapist's intervention, namely, that I should view my pediatrician as my savior might be a projection of a one-dimensional perspective. The therapist seemed to be saying, "you view your doctor as bad, but you should think of him as good." Frankly, I view him in this moment as a doctor doing his job to treat a sick patient. I saw him on several occasions in childhood and I suspect that my view of him is a composite of my various interactions with him. Keep in mind, I did not tell the therapist that I viewed the doctor as a bad actor either now or as a child. I simply reported events as I recalled them from childhood. I reported my emotional responses to those events as I recalled them. I offered a psychoanalytical reconstruction of my possible fantasies that were mobilized in reaction to the incident; that is, I offered the reconstruction that I might have viewed the doctor as an *intruder at an unconscious level*. I suggested that the incident might have been traumatic. I never said the doctor was *bad*.

I offer an interpretation of the therapist's peculiar construction of my report. Is it possible the therapist's comment was a *displacement*? Did the therapist perhaps identify with my pediatrician? Was she thinking unconsciously, "You condemn your pediatrician just as you condemn me. I, your therapist, am your benefactor—your savior. You don't appreciate that. You seem to think I am trying to harm you. You criticize me, you write critical letters about me, you resist my interventions. In fact, I am your savior." Of course, I have never condemned the therapist and I did not condemn my pediatrician; this is the therapist's own defensive gloss.

Displacement is an unconscious defense mechanism whereby the mind substitutes either a new aim or a new object for goals felt in their original

form to be dangerous or unacceptable. Feelings that are connected with one person can be displaced onto another person. A subsidiary form of displacement can occur *within* the countertransference when the therapist disguises countertransference references by applying them to a third party. Casement, P., *Further Learning from the Patient: The Analytic Space and Process*. In the therapist's construction: "He criticizes his pediatrician just as he criticizes me. His childhood doctor was his savior. I am this patient's savior and he doesn't recognize that."

I am intrigued that the therapist's projection of a one-dimensional view of a person as either all good or all bad parallels the therapist's simplistic and naïve invocation of CBT technique at this session that took the form of the therapist attempting to reframe my supposed perception of my pediatrician, in effect, saying: "You think your doctor was a bad guy. But in fact he was a good guy. If you see him as a good guy, your psychological distress about this childhood incident will be ameliorated." But again, what about my possibly traumatic response to the incident? How will my adopting a view of the doctor as a "good guy" affect the childhood experience of terror, mortification, confusion and loss in that moment and the possible enmeshment of the experience with my inner world of fantasy?

The issue is not my conscious beliefs or factual assertions about my pediatrician, but how I might have been emotionally affected by a traumatic experience. The issue is not my beliefs – which can be addressed with a CBT approach – but my lived experience (and associated unconscious feelings and defensive distortions) and how I unconsciously registered that experience: issues that lie beyond the ministrations of CBT technique. As I have said in the past: *We are not thinking machines. We are feeling machines that think.*

It is important to see my thoughts and feelings about the doctor to involve vertical splitting, a split between an adult "observing ego" and a

childhood “experiencing ego.” My adult observing ego views the doctor in logical and objective terms as a health provider helping a sick patient. But there is an issue of disavowal here since outside of conscious awareness is the experiencing ego of a three-year-old who experienced a traumatic event involving feelings of terror, confusion, and loss.

To be effective as a defense, disavowal does not require an abandonment of, or any deficit in, the capacity for logical thought. Disavowal blocks the formation of a bond between perception and affect. The vertical split shows itself phenomenologically as two parallel experiences of perceptions—both a knowing and a not-knowing of the disavowed content, that is, the affects surrounding the traumatic experience. For the disavowing patient, by definition, the usual continuity between the mental registration of something (by the observing ego) and its affective consequences (registered by the observing ego) is not to be expected. See, Giacomantonio, S.G., “Disavowal in Cognitive Therapy: The View from Self Psychology.”

But let us think of the assumptions and aims of cognitive therapy: “Cognitive therapy claims to effect its cures by altering dysfunctional mental patterning. Mental patterning is believed to be responsible for pathology insofar as it both constructs subjective experience and organizes behavior, by processing inner and outer sensory perception in an idiosyncratic way. We can summarize that the path to cure through cognitive therapy usually begins with the verbalization by patient and therapist of these organizing patterns (i.e., schemata, core beliefs). Inevitably, any pathology can be reduced to irrationality in either the content of the cognitions, or in the thinking and reasoning processes, even where the cognitive distortions deal merely with misperception or misinterpretation of ‘reality.’ As we read in *Hamlet*, “nothing is right or wrong, but thinking makes it so”; one is depressed not about the world, but because of one’s perception and interpretation of it. As such, we might assume a reduction in psychopathology once the patient’s thought

processes are more reasonable, and his perceptions of reality are more realistic. Reality is usually enough, if not to make one perfectly happy, at least to make one non-pathological and no longer depressed.”

Giacomantonio, S.G., “Disavowal in Cognitive Therapy: The View from Self Psychology.”

The implication is clear. CBT reframing, which is premised on effecting cure by means of reframing dysfunctional mental patterning, will be ineffective in the treatment of patients whose core pathology involves vertical splitting, that is, a split between the conscious, logical perception of traumatic experience and the unconscious feelings associated with and psychic transformations of traumatic experience. When the therapist says that my pediatrician was my *savior*, she will not hear an argument from me. But split off from my present logical and realistic perception of the doctor are unconscious feelings and fantasies that lie beyond my conscious access and control: namely, the feelings and fantasies of a three-year-old child.

Experienced and knowledgeable trauma therapists are aware of the inherent limitations of CBT reframing and are also aware that the use of CBT reframing in cases of trauma-induced vertical splitting can be deleterious. “Certain central aspects of the cognitive model may, if adhered to clinically, fail to heal or, at worst, enhance such pathology [i.e., vertical splitting], with or without the amelioration of observable symptoms, not because of any specific intersubjective circumstance, or therapeutic technique, but because of essential (indispensable) tenets of the cognitive theory itself—the theory itself contains the problem. . . . Symptom amelioration is not desirable unless it is achieved via the dissolution of the vertical split.” Giacomantonio, S.G., “Disavowal in Cognitive Therapy: The View from Self Psychology.”

There is an interesting symmetry between the therapist’s one-dimensional moralizing – that is, her depiction of persons as all good or all bad – and

her simplistic and naïve use of CBT technique, which can also be seen as one-dimensional.

“In addition to overlooking the central role of affect in mental life [such as feelings of terror, horror, and helplessness that can trigger a trauma response], cognitive psychology adopts a *one-dimensional view* of unconscious mental processes. The cognitive understanding of the unconscious is limited to rational processes for assimilating and processing information taken in through the senses. The cognitive unconscious ‘is a fundamentally adaptive system that automatically, effortlessly, and intuitively organizes experience and directs behavior.’ The idea of a cognitive unconscious explains how we drive a car or remember faces, but it does not explain why, for example, a person might suddenly develop an inability to eat in public without experiencing debilitating physical symptoms, be unable to complete a major writing assignment, or subject himself repeatedly to disappointment in love. Given its narrow focus on information processing and other rational processes, cognitive psychology does not account fully for common psychological phenomena, such as reaction-formation, denial, rationalization, obsession, paranoia, dissociation, phobia, repression, regression, [displacement,] and transference, all of which operate to some extent at an unconscious level and cannot be explained by cognitive processes alone. Overall, because cognitive psychology remains ‘explicitly concerned with the fashion in which incoming stimulus information is processed in order to extract meaning from it,’ it cannot grapple in any serious way with the effect that unconscious emotions, motivations, and conflicts have on everyday conscious behavior.” Dailey, A.C., *The Hidden Economy of the Unconscious*.

One wonders whether it is the one-dimensional aspect of cognitive-based therapy technique that appeals to this therapist precisely because of her possible global preoccupation with one-dimensional thinking that also encompasses her tendency to focus on one-dimensional perceptions of

people as either all-good or all-bad and her tendency to downplay the role of feelings. In notable ways, the therapist's concerns about moral valuations trump any concern for the patient's feelings associated with disturbing experiences. Let us remember that at the first session the therapist focused on moral valuations about my father and me in connection with childhood beatings, ignoring the associated feelings of terror, betrayal, and confusion. When I reported that my father used to beat me as a child she responded: "Your father shouldn't have done that. You did nothing wrong. You were just a child. Children misbehave. Your father shouldn't have beaten you." In effect, she was saying: "You were a good guy. Your father was a bad guy." Again, how does moralizing about the beatings – that is, assessing the moral equities of the parties – address my *feelings* of terror, betrayal, and confusion?

My psychological test report stated that it was the following aspects of the beatings that were pathogenic: "Typically, the parental expectations or rules were enforced quite literally, without consideration or flexibility regarding the needs and distresses of the child. Parental (or other family members') tempers are apt to have been intensely *threatening* and *frightening* to the person as a small child. The parents were experienced as punitive and coercive of the child's will and indifferent to the child's distress, and punishments were often severe." What the test report is describing is psychological *terror*. The test report did not state that the pathogenic aspect of the beatings centered on the threat they posed to my self-esteem or that they promoted self-blame.

TRAUMA AND MORAL QUESTIONS

Psychological trauma is a type of damage to the mind that occurs as a result of a distressing event. Trauma is often the result of an overwhelming amount of stress that exceeds one's ability to cope, or integrate the emotions involved with that experience. Trauma may result

from a single distressing experience or recurring events of being overwhelmed that can be precipitated in weeks, years, or even decades as the person struggles to cope with the immediate circumstances, eventually leading to serious, long-term negative consequences. Immediate responses to trauma might include *terror, helplessness, or horror*.

Exposure to a traumatic event or series of chronic traumatic events activates the body's biological stress response systems. Stress activation has behavioral and emotional effects that are similar to individual post-traumatic stress symptoms. Further, an individual's biological stress response system is made up of different, interacting systems, that work together to direct the body's attention toward protecting the individual against environmental life threats and to shift metabolic resources away from homeostasis and toward a "fight or flight" (and/or freezing) reaction. The stressors associated with the traumatic event are processed by the body's sensory systems through the brain's thalamus, which then activates the amygdala, a central component of the brain's fear detection and anxiety circuits. Cortisol levels become elevated through transmission of fear signals to neurons in the prefrontal cortex, hypothalamus, and hippocampus, and activity increases in the locus coeruleus and sympathetic nervous system. Subsequent changes in catecholamine levels contribute to changes in heart rate, metabolic rate, blood pressure, and alertness. This process also leads to the activation of other biological stress systems. De Bellis, M.D. and Zisk, A.B., "The Biological Effects of Childhood Trauma."

From a psychoanalytic perspective trauma is seen to breach the stimulus barrier. Ego functions (motility, perception, judgment, time sense) will be temporarily overwhelmed. The subsequent attempts at mastery may involve turning passive into active through sexualization and repetition, or re-enactment. Fernando, J., "The Exceptions: Structural and Dynamic Aspects."

Trauma, as analysts see it, will lead to the mobilization of unconscious fantasy. Freud seems to have been concerned with the way in which trauma is not a simple or single experience of historical events but that events, insofar as they are traumatic, assume their force precisely in their temporal delay and their enmeshment with the individual's inner world of fantasy. It is my understanding that in the psychoanalytic context trauma both draws on preexisting fantasy and can be a driver of fantasy that is refashioned by the traumatic experience. The "radical potential of psychoanalysis" is to move beyond historical events to retell through the patient's narrative the "lost truths of pain among us." See, *Trauma: Explorations in Memory*, Caruth, C., ed. Such a perspective seems to me to assume that the moral equities of the actors in a traumatic event — both instigators and victims — as well as a journalistic concern for accuracy in retelling the event take second stage to the way the individual has unconsciously registered the experience and has woven the event into his internal drama. George Steiner, speaking as a non-analyst, frames the analytic perspective as an almost Homeric enterprise in which historical (traumatic) events — as with the Trojan War of the Odyssey — are the stepping stone to a mythic retelling: *It is not the literal past that rules us, save, possibly, in a biological sense. It is images of the past. These are often as highly structured and selective as myths. Images and symbolic constructs of the past are imprinted, almost in the manner of genetic information, on our sensibility.* Steiner, G. In *Bluebeard's Castle*.

It is my understanding that trauma is, to a large extent, an extra-moral phenomenon that occurs beyond the rectitude of the victims or instigators. In important ways, whether an event is traumatic to an individual — in a biological as well as deep psychological sense — does not depend on the motives, intent, goodness, or lack of goodness of the instigator. The biological and psychological effects of *fear, horror, and helplessness* in the victim will arise regardless of the probity of the instigator. To paraphrase Nietzsche: *Trauma is not a moral phenomenon, though one can make moral interpretations of the actions leading to trauma.*

A traumatic event might raise moral or philosophical questions of right and wrong but these issues lie beyond the physiological and psychological responses of the victim. I am reminded of George Steiner's book, *The Portage to Cristobal of A.H.* In this literary and philosophical novella Jewish Nazi hunters find a fictional Adolf Hitler (A.H.) alive in the Amazon jungle thirty years after the end of World War II. The author allows Hitler to defend himself when he is put on trial in the jungle by his captors. There Hitler maintains that Israel owes its existence to the Holocaust and that he is the "benefactor of the Jews." Philosophers and novelists can argue about the moral value or depravity of Hitler. Philosophers and novelists can propose that Hitler might be viewed as a God-sent savior of the Jewish people who helped the Jews realize a millennial-old dream to recreate a Jewish homeland in Palestine. But the presumed saintliness of Hitler concocted by intellectuals is irrelevant to the outcome of the policies of the Third Reich that were traumatic to its victims. I suppose one could say to a religious Holocaust survivor residing in Jerusalem, "Without Hitler and the Nazi concentration camps, you would not be living the dream of a life in Israel. You would not live in the shadow of the Western Wall. Think of Hitler as your *savior!*" Even assuming the survivor accepted at an intellectual level that particular reframing of his traumatic experience, he would still struggle with the psychological and biological effects of loss, mourning, terror, helplessness and horror. Whether one conceives of Hitler as a monster or a saint will not affect the physiological trauma-induced changes seen in trauma survivors. Whether one conceives of Hitler as a monster or a saint will not affect the survivor's mobilization of unconscious fantasy in the wake of trauma. The consequences of the horror of the Holocaust – the aftermath of the things *done* to the victims – cannot be *undone* by intellectualized moral reframing.

Another example. A driver is seriously injured in a car accident. He was blameless, legally and morally. The other driver was intoxicated; he operated his vehicle with reckless disregard for the safety of others. The

intoxicated driver's recklessness caused serious injuries to the accident victim; he was blameworthy, legally and morally. The injured driver is rushed to a hospital emergency room. While hospitalized doctors discover an early stage cancer in the accident victim that is routinely fatal if detected at a more advanced stage. Doctors remove the cancer, ultimately saving the man's life. But the patient was psychologically traumatized in the accident and will require intense psychological treatment for post-traumatic stress disorder. In subsequent psychotherapy, the therapist attempts to *reframe* the survivor's thinking, encouraging him to think of the other reckless driver as his *savior*. "The other driver was your *savior*. He saved your life. Without his recklessness, your cancer would have eventually killed you." Would such reframing constitute an effective treatment for post-traumatic stress symptoms? How? Again, the biological and deep psychological effects of *fear*, *horror*, and *helplessness* in the victim will arise regardless of the moral equities of the parties. In attempting to reframe the accident victim's perceptions of the perpetrator, it's as if that therapist has made the terrifying screech of the automobile accident that injured her patient sound like music.

Therapy Session: September 21, 2018

Dr. Alfred Adler, who was formerly an analyst, once drew attention in a privately delivered paper to the peculiar importance which attaches to the very first communications made by patients.

–Sigmund Freud, “Notes Upon a Case of Obsessional Neurosis.”

I have achieved what I set out to achieve. But do not tell me that it was not worth the trouble. In any case, I am not appealing for any man's verdict, I am only imparting knowledge, I am only making a report. To you also, honored Members of the Academy, I have only made a report.

–Franz Kafka, *A Report to an Academy*.

The very first communication:

PATIENT: So I want to talk about something I never talked about before. I've never told you about this. Actually, I never told any therapist about this. It's something I was thinking about in the last few days. When I was a freshman in college, that was in 1971, I was 17 years old – it was the fall semester – I took an introductory English course. It was a writing course. We had to write paragraphs about different subjects. So one time the teacher had us look at a picture in a book. It was a picture of a young woman, she was seated on the floor in an empty room. Maybe she had her head in her hands. I don't exactly remember now. Anyway, we had to write a paragraph about that. We had to talk about what the woman was doing. Why she was sitting in an empty room. What she was thinking about. What her thoughts and feelings were. These were all projections, of course, because we really had no idea what was going on in the woman's mind, or why she was sitting there. It's like the Thematic Apperception Test. Do you know about that? I took that test. It's a psychological test. They show you ten pictures and you have to talk about

what each picture shows. You have to make up a story about what's going on in the picture. It's all projections of course. And those projections — the things that the test subject says about the pictures — tell the test evaluator things about the person doing the test. So we wrote our paragraphs, then the teacher read some of the paragraphs in class. And I was astounded by what they wrote. I couldn't believe it. They talked about how the woman was lonely and sad. How she was depressed or maybe suicidal. I couldn't believe it because I wrote something totally different. I wrote that the room was a ballet studio. That the woman was a ballet dancer who had practiced for hours and now she was feeling good about herself. She had achieved what she had set out to achieve.

[May we say that my projections suggested that I had a high level of autonomy? Unlike the other students in the class, I did not see the figure in the photograph as separated from other persons or dependent on other persons for self-esteem. It did not appear to me that she *felt* isolated from others, simply that, as a matter of fact, she was seated alone; hence, my lack of concern about her being lonely. Her mental state, in my projection, was one of pride and self-satisfaction. May we say that I projected onto the figure in the photograph feelings of self-reliance, solitariness, resourcefulness, individualism, and self-sufficiency? Perhaps. And perhaps some of the other students' projections of sadness and loneliness indicated feelings in those students that were associated with the traits of being group-oriented, affiliative, and a joiner: traits that might cause them to associate the state of isolation with loneliness and sadness. Might we speculate that for me the state of isolation is not a taboo state—one that I associate with feelings of shame? Might we also speculate that for the other students social isolation was seen as a taboo state—one that was associated with feelings of shame? See, e.g., Laing, O. "Why do we feel shame about loneliness?"]

[Later in the session, I raised the following seemingly unrelated topic.]

Subsequent communication:

PATIENT: We talked about my primary care doctor, Dr. P— a few sessions ago. How he took out a protection order against me because he said I was stalking him. I had been posting items about him on my Twitter. I posted 450 items about him from late September 2015 till June 2016.

[Note the manic quality of my preoccupation with my primary care doctor. My months-long obsession involved my writing several Tweets each day that referred to him. Salman Akhtar has pointed out that idealization can be a *manic defense* against sadness, loss and mourning. I will discuss the issue of pathological mourning, and its possible role in my fantasies about Dr. P—, later in this letter.]

PATIENT: My posting items on the Internet about Dr. P— links up with my paranoia. I believe that there's someone out there — I don't know who, but somebody associated with the law firm where I used to work — who tracks my activities and communicates with people about me. Like, for example, I think the mystery person communicates with my sister. And I think the mystery person communicates with people in my library. And I felt that the mystery person communicated with my previous primary care doctor, Reggie Elliott, M.D. So when I got a new doctor, Dr. P—, in late September 2015, I thought that the mystery person would communicate with him. So I posted items on Twitter to let the mystery person know that I was seeing Dr. P— in the hopes that he would communicate with Dr. P—. I kept posting things on Twitter to promote conversations about me between the mystery person and Dr. P—. And you know, I actually formed the impression Dr. P— was in

communication with the mystery person. I had four consults with Dr. P—. And at one of them — I remember this — we were talking about my weight. I thought I was overweight and I told him I wanted to lose weight. And he said that losing weight is simply a matter of calories in and calories out. You need to eat fewer calories and also exercise, which will burn calories, and you will lose weight. So this is the thing. And I remember this exactly. He said to me, “What is your *ideal* weight?” And I saw meaning in that. Well, maybe it’s my paranoia. But I saw meaning in that statement, “What is your *ideal* weight?” He seemed to look sheepish when he said the word “ideal” and I saw meaning in that. I read his statement as “What is your *Ideal*?” I had written on the Internet how I idealized Dr. P—. And I think the mystery person told Dr. P— about that. So I suspected that Dr. P— knew all about me and what I was writing about him on the Internet. So when he took out the protection order, I thought it was fake because he claimed he was afraid of me. But my thought is that he wasn’t afraid of me — that he knew all about me. And I had the idea that he liked me. So I think the whole protection order thing was a fake and that it was contrived by his lawyers.

THERAPIST: How did you feel when you had to appear in court?

PATIENT: You know I sat there and I was thinking, “Well, this is just another one of my crazy escapades.” You know, like, “How do I get involved in these crazy things?”

[After the session, I associated to the 1950s TV sitcom, *I Love Lucy*. Many of the episodes of that TV series depicted the fictional character Lucy Ricardo getting involved in bizarre situations, often related to her desire to break into show business. Then I thought of the famous Laurel and Hardy line: “Well, here’s *another fine mess* you’ve gotten us into.” My associations were comic. Sitting in the courtroom I was thinking of the

“fine mess” I had gotten myself into.]

THERAPIST: Were you having feelings of shame in the courtroom?

PATIENT: I don’t think so. I wasn’t aware of feelings of shame. You know, I was feeling kind of pumped up. You know, I’m a lawyer, so the idea of being in court kind of pumped me up. I remember we had to appear before the judge: me, Dr. P–, and his lawyers. We had to introduce ourselves. And I introduced myself first. And in a friendly, booming voice I said, “Good morning, your honor. My name is Gary Freedman.” And I may have said, “How are you today?” And I remember the judge smiled at me. And I noticed that. So, yeah, I was feeling kind of pumped up about being in court and appearing before the judge. [My description of my feelings in the courtroom suggest phallic exhibitionism, that is dramatic self-aggrandizement. Another interpretation is that my landing in court because of my Internet activities – namely my obsessive postings about my primary care doctor – was an example of “negative exhibitionism,” or the habit of making “a spectacle of oneself,” as related, in the view of psychoanalyst Edmund Bergler, to preoedipal trauma and conflict.

That I might have felt “pumped up” about appearing in court should not have surprised the therapist. At an earlier session, I reported a tangentially-related anecdote:

When I was in my second year of college, I took an introductory course in public speaking. We had to give three speeches during the course of the semester. After one of my speeches the instructor said that my speech was the finest speech any student had given in about the last three semesters. Then, in my next class – I remember it was biological science, a large lecture hall class – there was a student who had been in my speech class. He was sitting across the lecture hall and yelled

out to me, ‘You are so weird, man! You are so totally weird!’

I went on to report to the therapist that I seemed to feel pride about the speech and not shame in the face of a fellow student’s harsh criticism: *I told the therapist about the topic of my speech that had been singled out for praise. I had told my college class that people should not seek pleasure in life, that a person should just live and if one finds something pleasurable he should enjoy the experience, but that he should not make pleasure-seeking his goal in life. These are peculiar ideas for an 18-year-old to express. Most teenagers are pleasure-seeking creatures. They live for pleasure. In fact, my instructor commented: “You must be a lot of fun at parties!” Did my fellow student, my peer, react negatively to my thinking, my rationality and my individuality? Was the fellow student’s negative reaction to me fundamentally a negative reaction to my autonomy and the fact that I expressed values inconsistent with those held by most teenagers?*

The therapist’s attribution of shame to me in this session (or her projection of shame) is noteworthy. In several past instances the therapist has imputed (or projected) shame to me in situations in which I was not consciously aware of feelings of shame.

-At an early session I reported to the therapist that I experienced feelings of alienation in social situations. The therapist replied: “Let me show you how that is actually a fear of rejection,” implying that, in the therapist’s view, an individual’s sense of being different from others will not be associated with neutral feelings of distinctiveness, but negative feelings of shame about being different from others, with associated fears of rejection.

-At another session, I reported a coworker’s comment: “We’re all afraid of you, we’re all afraid you’re going to buy a gun, bring it in and shoot everybody.” The therapist inquired: “Did that make you feel bad?” The therapist thereby projected feelings of shame to me in the face of another

person's negative evaluation.

-At yet another session, when I reported that I had sent many letters to the FBI about my situation, the therapist inquired: "Are you concerned about how your letters are received by the FBI?" The therapist thereby projected shame to me about possibly being evaluated negatively by federal law enforcement.

I must emphasize that I am not appealing for any man's verdict. I am not preoccupied with other people's negative evaluations of me. Other persons' negative evaluations will not necessarily cause me to regress to a shame state.

The issue of embarrassability (i.e., susceptibility to embarrassment, and by extension, the susceptibility to shame) as it relates to one's self-concept (or self-construal) has been studied by psychologists. One study found that the strength of the independent self-construal (the image of self as separate from others) is negatively correlated with embarrassability. In other words, independent-minded people will have a low susceptibility to feelings of embarrassment. Second, the strength of the interdependent self-construal (the image of self as connected with others) is positively associated with embarrassability. That is, interdependent people — persons preoccupied with attachments — will have a relatively high susceptibility to feelings of embarrassment. Many prior studies have associated embarrassability with social deficiencies — such as deficiencies in an independent self-concept and the need for social support to maintain self-esteem. Conversely, embarrassability correlates negatively with self-reliance, solitariness, resourcefulness, individualism, and self-sufficiency (qualities found by Raymond Cattell to characterize persons at a high level of ego strength). Singelis, T.M., "Culture, Self-Construal, and Embarrassability."

These findings suggest that the therapist's interpretations over time that impute shame to me in various contexts may be related to her own interdependent self-construal, that is, her image of herself as related to others. Is it possible that the therapist's emphasis on social relatedness ("You need to take risks with people," and "Wouldn't you like to go to dinner now and then with friends?" etc.) is rooted in the therapist's use of relatedness as a *defense against shame*? That is, for the therapist perhaps social isolation is a taboo state, one that involves a regression to shame. In a word, I will venture to say that the therapist is shame-prone.

We may strongly infer that my traits of self-reliance, solitariness, resourcefulness, individualism, and self-sufficiency are *protective against shame*. I do not view social isolation as a taboo or shame state; I am not necessarily prone to view other persons' negative evaluations of me as a narcissistic injury; and I do not require relatedness as a defense against shame.]

THERAPIST: Do you take ownership for what happened with your doctor?

PATIENT: Well, yes. I mean, I wanted to get a reaction from Dr. P-. I didn't know how he would react. But I thought that if I kept posting things about him, it would provoke some kind of a reaction from him. I had no idea how he would react. But I bank on the idea that if I do unusual things I will get a reaction from a person. Then I have confidence in my ability to exploit the person's reaction, no matter how a person reacts to me. (I kind of have a gift for that.) I'm an opportunist. I take advantage of situations. I provoke people to act and then I take advantage of how the person reacts. Like, for example, when I got fired from my job [in 1991], they said I had severe mental problems and that I was potentially violent. I didn't deliberately provoke the employer to say that, but I took advantage. I turned around and used the employer's

statements to get disability benefits. The employer had no idea that when they said what they said about me that I would apply for and qualify for disability benefits. They just wanted a legal justification to explain away their job termination. But I took advantage of what the employer did.

[Note the *sense of entitlement* implicit in my statement that I did not really believe that I was disabled when I applied for disability benefits. I admit in the above clinical report that my action in taking advantage of my employer's fraudulent disability determination was purely exploitive. I took advantage of, or exploited, the employer's apparent act of perjury in filing false written statements about my mental health with a government agency by thereafter filing those same perjured written statements with the Social Security Administration to obtain disability benefits. I will return to the issue of "entitlement" later in this letter.]

PATIENT: Same thing with Dr. P-. I provoked him hoping for some response. I got a response, and I was able to convert that response into a possible criminal investigation by the FBI (i.e., an investigation into possible perjury by the doctor and associated federal crimes). I filed a criminal complaint against Dr. P-, alleging that his protection order affidavit against me was perjured, which violated my Constitutional rights. I do those kinds of things all the time with people. I provoke people, confident in my ability to make hay with the reaction, no matter what the reaction is. I can't know how a person will react, or if he will react at all, but I have confidence that I will be able to take advantage of the person's reaction no matter what it is. I am an opportunist.

[Is it possible that I secretly viewed my courtroom appearance as my opportunity to "break into show business," like the TV character, Lucy Ricardo? Perhaps we may say that with the court's "verdict" "I achieved what I set out to achieve."]

PATIENT: Like I said I think Dr. P-'s lawyer put him up to getting the protection order.

THERAPIST: Maybe the lawyer didn't put him up to getting the protection order. Maybe he did that on his own. Maybe he was really afraid of you.

[The therapist failed to see the psychological implications of what amounted to my *fantasies* about Dr. P-.

-I had the fantasy that Dr. P- liked me. There is no factual support for that belief. Yet, does that belief have psychological meaning regardless of its factual accuracy?

-I had the fantasy that Dr. P-'s act of aggression, his taking legal action against me, was the result of outside influence (that is, the action of his lawyer). There is no hard evidence for that. Yet, does that belief have psychological meaning regardless of its factual accuracy?

-In the months prior to the imposition of the protection order I engaged in a determined effort to come to Dr. P-'s attention. Did my action in posting 450 Tweets about him have a concealed psychological meaning? If we remain on a factual level, as the therapist did here, my reports about Dr. P. carry little psychological value. The therapist ignored the fact that, indeed, my thoughts about Dr. P- are *analyzable fantasies*, rich in psychological implications about my early childhood and early childhood attachments. That is, my behaviors in relation to Dr. P and my fantasies about him may relate back to my internal working model. Again, because the therapist emphasized *factual correctness* (as if the important issues were simply “who prompted the protection order” and “whether the doctor was in fact afraid of me”) she utterly ignored the important clinical

significance of my report. In psychological terms, my relationship with Dr. P— does not comprise simply the objective facts of the actual doctor-patient relationship, but also what type of relationship I *wished for* and how I *construed* the objective facts.

We can place my fantasies about Dr. P— in the context of my idealization of him. I return to Kohut's case of Mr. U that I have referenced in several earlier letters:

Mr. U turned away from the unreliable empathy of his mother and tried to gain confirmation of his self through an idealizing relationship with his father. The self-absorbed father, however, unable to respond appropriately, rebuffed his son's attempt to be close to him, depriving him of the needed merger with the idealized self-object and, hence, of the opportunity for gradually recognizing the selfobject's shortcomings.

Kohut, H., *The Restoration of the Self*. To some extent we may view my fear of maternal engulfment and my corresponding need for an idealized male as a defense against that fear as a universal struggle; perhaps, the struggle is only particularly intense in me. Blos has written: "The role of the early father was that of a rescuer or savior at the time when the small child normally makes his determined effort to gain independence from the first and exclusive caretaking person, usually the mother. At this juncture the father attachment offers an indispensable and irreplaceable help to the infant's effort to resist the regressive pull to total maternal dependency, thus enabling the child to give free rein to the innate strivings of physiological and psychological progression, i.e., maturation." Blos, P. "Freud and the Father Complex." Applying Blos, we may perhaps say that my failure to resolve the dyadic father idealization that emerged at the earliest stages of development has had significant, even profound, reverberations in my adult life. My dyadic father attachment was never subjected to a sufficient or lasting resolution during my adolescence,

namely, at that period in life when the final step in the resolution of the male father complex is normally transacted. Blos, P. "Freud and the Father Complex."

Let us return to my fantasies about Dr. P— and see how they might apply to my early relationship with my father:

-I had the fantasy that my father loved me. My father's remoteness or inaccessibility provided little factual support for that belief. (The father's presence in a young boy's life can be seen as one "either actual, construed, or wished for." Blos, P. "Freud and the Father Complex.")

-I had the fantasy that my father's acts of aggression (his beating me in early childhood) were the result of outside influence (that is, the actions of my mother). My father's beatings would be triggered by my mother reporting my misdeeds to my father.

Compare the psychological test report: "Mr. Freedman's father was physically abusive toward him beginning at an early age. . . . Mr. Freedman reported that he felt more intense anger at his mother for not protecting him from his father's abuse, as opposed to conscious anger at his father."

-Did I fantasize about gaining my father's attention in early childhood (as I did with Dr. P—)? I don't know.]

PATIENT: So, as for Dr. P— he could be in big trouble. You know, because of my criminal complaint he could face criminal charges. He could lose his medical license. But you know what? I don't care. I have no remorse about my actions. No remorse at all. I feel betrayed by Dr. P—. I feel deeply betrayed by him.

[My reference to a sense of *betrayal* in connection with Dr. P— is especially significant in light of the context of my earlier references at this session, namely, my references to my *idealization* of Dr. P—, my sense of *entitlement* (centering on filing a false claim for disability benefits), and the *manic* quality of my act of obsessively posting items about Dr. P— on Twitter (which I referenced early in this letter).

Kieffer has identified a personality type with a high level of narcissistic and schizoid tendencies, traits that I have, that encompasses concerns centering on *betrayal*, *idealization* (remember that *idealization* can be a *manic* defense against unconscious pathological mourning, loss, and sadness), and *entitlement* resulting from a sense of victimhood. Kieffer, C. "Restitutive Selfobject Function in the 'Entitled Victim.'"

Kieffer has described so-called restitutive fantasies in such an "entitled victim." Such individuals frequently display a relational pattern characterized by *primitive idealization of an unavailable other* to shore up a fragile self-state. While often initially presenting in consultation as highly related, there is, in actuality, limited capacity for intimacy because that would threaten the fragile nature of the *idealization* due to increased potential for narcissistic injury. Such persons are thus markedly *schizoid* as well as *narcissistic*, since they must achieve a "schizoid solution" of distance in order to preserve connection with an *idealized object*. The entitled victim stance is thus part of their self-protective strategy, which is intended to protect against re-injury but instead virtually guarantees it and also interferes with repair. This fantasy often contains elements of *union with an idealized parent*, thus it is also an unconscious strategy to avoid *loss and mourning*, in order to retain the transference object, and, as such, is a form of *melancholia*. (According to Melanie Klein and Salman Akhtar,

idealization can be a *manic* defense against sadness, loss, and mourning.) Such individuals have a conscious sense of victimization (and an associated sense of *entitlement*) that results from their having been badly treated or subject to misfortune. Their "positive selfobject" needs become functionally structured around a conviction of *entitled victimhood* that progresses into an organizing feature of the personality. Significantly, these individuals may erupt in narcissistic rage (with underlying feelings of *betrayal*) when a sudden and traumatic de-idealization occurs, a state which may be mobilized when the *idealized other* cannot participate in the enactment of the fantasy.]

Therapy Session: October 2, 2018

Man lives by metaphor; his mind is a poetry-making organ and a myth-making and history-making organ. Once past infancy, we have an intense need for psychic synthesis, continuity, and causality. We weave our memories [of real events, or objective reality] into narrative, from which we construct our identities . . .

*-Leonard Shengold, *Soul Murder: The Effects of Childhood Deprivation and Abuse.**

PATIENT: I was thinking of something. You know, I thought that maybe it would be a good idea if you would contact a psychoanalyst about me. I was thinking that maybe you could send my letters to the analyst, ask him to review the letters and perhaps offer any thoughts he might have about the letters I wrote to you. You know, these days there are social workers who have psychoanalytic training - they're psychoanalysts. I did some research and came up with three social worker psychoanalysts. Maybe you could contact them and see if they would be willing to review my letters to you and offer you insight into the letters.

[From a psychodynamic perspective, my proposal can be seen in the following symbolic terms. I view the psychoanalyst as "self" in the sense that I identify with the analyst's emphasis on the inner world and the importance the analyst attaches to symbolization. The therapist (social worker) is non-self; the "psychoanalyst-consultant" is part-self and part non-self (both social worker and part psychoanalyst), and thus an "intermediate object" between self and non-self.]

THERAPIST: Why would that be beneficial? What would you be trying to accomplish?

[Note that the therapist seemed to focus on the advisability, practicality or usefulness of the proposal.]

PATIENT: Well, I thought that you could be a receptacle for their ideas about me. I really don't think you're in a position to evaluate the indications for psychodynamic therapy for me. You're not a psychodynamic therapist, so you really can't say how I might benefit from psychodynamic therapy. It's like, for example, if you were a cardiologist and I had kidney problems. You wouldn't be in a position to say how I might benefit from a certain kidney procedure. It would take a kidney specialist to assess the best treatment for my kidney problems. I think I could benefit from psychodynamic therapy. Dr. Acharya [the attending psychiatrist at the D.C. Department of Behavioral Health] said I need psychodynamic therapy.

THERAPIST: Dr. Acharya's opinion is just one opinion.

PATIENT: Well, your opinions are just one opinion. Why should I accept anything you say? You're just one person. I could just as easily say your opinions are just one person's opinion and reject everything you say.

THERAPIST: You generally reject everything I say anyway.

[The therapist and I continued a give-and-take regarding my desire for the therapist to contact a psychoanalyst about me to obtain a psychodynamic viewpoint about my personality problems. The upshot was that the therapist did not agree to contact a psychoanalyst. Our give-and-take remained on a literal, reality level about my desire for the therapist to contact a psychoanalyst. The therapist failed to see any symbolic content in my opening statements. For her, my request that she contact an outside psychoanalyst-consultant remained simply a request that she contact an outside psychoanalyst-consultant. Nothing more. "Things are what they are."

A brief time later, I talked about the issue of alienation. The therapist

failed to see the deep symbolic relationship between, on the one hand, my suggestion that she consult a psychoanalyst about me, and on the other, the following thoughts I offered about alienation and self-estrangement.]

PATIENT: I just don't think you're psychodynamically oriented. You're not really interested in internal processes. You put everything on an interpersonal plain. Like for example, last time we talked about my feelings of alienation. You were talking about the fact that I feel alienated. You were picking up on ideas that I have talked about. And I thought that you were talking on an interpersonal level. I got the impression that when you talked about my feeling alienated you meant that I felt alienated from other people. And, you know, that's the thing. That from the perspective of internal processes – from a psychodynamic viewpoint – I wasn't talking about feeling alienated from other people. I was talking about something internal – that fundamentally, I feel alienated from myself. And you don't see that because you're interpersonally oriented. So you see everything from an interpersonal perspective – how everything about me relates to my relationships with other people. You don't look at internal processes, like a psychodynamic therapist would. When I talk about a sense of alienation, I'm talking about something that is fundamentally internal – not interpersonal. Fundamentally, when I talk about alienation, I'm talking about feeling alienated from myself. Not other people. Like, for example, with dissociative identity disorder – multiple personality disorder – you know, people, who have multiple personalities. When they are talking from the perspective of one personality, they are actually alienated from all their other personalities. That's fundamentally internal and not interpersonal. They are alienated from themselves – not from other people. And I was thinking of schizoid disorder, where a person has major splits in his personality, he is alienated internally from all the other split off aspects of his personality. Even narcissistic disorder can be thought of as involving this kind of internal alienation. You know the story of Narcissus and how he saw his reflection [*his mirror image*] in the water – and he idealized that

reflection. So there was his core self, but there was also his idealized self [*his mirror image*] – and his core self was alienated from the idealized self. In that sense the narcissist is alienated from himself – not alienated from other people. So, we can say that in a certain sense the narcissist has an internal sense of alienation – it's not just that he feels alienated from other people.

[The therapist did not comment on this narrative. My intuitive sense was that she thought that I was attacking her and what I perceive as her fundamentally interpersonal orientation. I had the sense that the therapist thought that my ideas were far-fetched. In fact, the literature supports my point of view – that a sense of alienation has multiple meanings. A sense of alienation can refer to an interpersonal dynamic of estrangement from others, but can also refer to an individual's sense of self-estrangement, an inner sense of alienation: a sense of alienation from one's self.

Warren TenHouten has written:

"Alienation implies the experience of separation, from a person, object, or social situation. Perhaps the most profound level of alienation is estrangement from one's self. The modern individual's experience of 'self' can range from a sound sense of clear personal identity, meaningful purpose, and committed involvement in work and social life to the loss of self and state of inauthenticity, futility, discontent, depersonalization, or dissociation. In his seminal work on alienation, Seeman calls this negative condition "self-estrangement," and includes it as one of his original five varieties of alienation. Seeman notes the difficulty of defining self-estrangement, and suggests a three-part definition: (i) "the failure to satisfy postulated human needs"; (ii) "to be engaged in activities that are not rewarding in themselves"; and (iii) "*the individual's sense of a discrepancy between his ideal self and his actual self-image*" [as in the myth of Narcissus who fell in love with his idealized mirror image as reflected in

the water] (emphasis added). TenHouten, W. *Alienation and Affect*.

In the state of self-estrangement (or alienation from one's self), there exists the self and a portion of the self that is detached from the self; that is, the self is estranged from a portion of self that is viewed by the self as "non-self." As in vertical splitting, the first person "I" becomes the third person "he."]

DISCUSSION:

There is a particular construction of the world that brooks no uncertainty: "things are the way I believe them to be." The manifest, literal world of appearances is all that exists or matters. There is no other way! This can be a real boost to one's confidence – even though this conviction is based solely on our own thoughts or immediate experience. In psychotherapy, where a therapist has such a concrete outlook, the patient finds himself left with his therapist's one-dimensional view of the world in which the therapist's technique, to some extent, takes on the form of a rigid ideology; and other perspectives are never even considered. For this therapist, my proposal that she consult a psychoanalyst-social worker was what it appeared to be; a concrete proposal that she implement a particular course of action. Nothing more.

The counterpart to concreteness, or what many refer to as desymbolized thinking/experience, is more abstract thinking or "symbolization." Symbolization refers to a process whereby we can meaningfully understand that an event can be looked at from a variety of perspectives. Symbolization makes it possible to look at things in an "as if" way rather than as "true" or absolute. It is a process where we can view our thoughts as objects of our thoughts. We self-reflect. From a psychodynamic perspective, we would say that the more-desymbolized person has an impaired capacity for personal reflection and an impaired ability to think about the meanings that underlie the overt words and actions of other

people.

The very process of psychodynamic interpretation – that is, interpreting the underlying meaning of a manifest content from different perspectives to arrive at a latent content – constitutes a threat to the desymbolized person's defensive organization and so exacerbates the individual's literal-minded and passionate conviction in an absolute unchanging reality. See, *Absolute Truth and Unbearable Psychic Pain: Psychoanalytic Perspectives on Concrete Experience*, Frosch, A., ed.

In a previous letter I discussed my perception that my therapist has such a conviction in an absolute and unchanging reality: a conviction in a single truth. It is interesting to note that the psychoanalyst Fred Busch sees a deep connection between the literalness of desymbolized, concrete thinking and the "bureaucratization of thought and language" found in groups and organizations that has implications for the "absoluteness of political ideologies."

I had previously written with reference to my therapist:

Woody Allen once said: "All people know the same truth. Our lives consist of how we choose to distort it." May we paraphrase and say that it is our distortions of reality that make us individuals. Without our individual subjective reality, there would be only one rationality, one "absolute Truth" (as in a totalitarian state or a cult), we would all be the same – like undifferentiated infants in a maternity ward. We would have no individual identity. We would be reduced to the status of prisoners, dressed in identical garb and assigned numbers. Is an appreciation of individuals' subjective reality associated with an anti-authoritarian ideal and a respect for freedom of expression (such as writing)? (Letter – June 19, 2018)

At the outset of this session I proposed that my therapist submit my writings to a psychoanalyst-social worker who might review those writings and offer her psychoanalytic insights about me to the therapist. Through

the prism of her concrete, desymbolized thinking the therapist saw only the literal nature of my proposal. But is there an alternative point of view? Or even several different alternative points of view? Can we find symbolic meaning in the proposal? Are there deconcretized interpretations of the proposal that have psychodynamic or metaphoric meaning beyond the literal meaning or manifest content of my recommendation?

(a.) Intergenerational Transmission of Trauma

The therapist is aware of my family background. I have talked about my immigrant background: the fact that my maternal grandmother was an immigrant from Poland who never assimilated into American culture. My grandmother arrived in the United States in 1910 at age 18 with her newly-wed husband; upon leaving Poland, she never saw her family again. Her English proficiency was poor. My father used to say about her: "How can somebody live in a country for 50 years and never learn the language?" My grandmother's husband (my maternal grandfather) died in 1918, when my grandmother would have been 26 years old; my mother at that time was 3 years old and her only sibling, an older sister, was 5. The family was left to struggle in dire poverty.

In a previous letter I offered the following thoughts:

The literature confirms the serious emotional effects of loss and trauma (and material deprivation) across generations. Fonagy references a patient who appeared to live in the reality of the past of her father, a Holocaust survivor. The patient is noted to have retreated into a narcissistic grandiosity that could withstand the harsh conditions that her father had survived. What is at work in second-generation victims is not covered by the concept of identification; that it is tantamount to the patient's immersion in another reality. The mechanism of "transposition" resurrects the dead objects whom the caregiver (the survivor) cannot adequately mourn. The objects are re-created in the mind of the second-generation

survivor at the cost of extinguishing the psychic center of his own life. Fonagy, P. "The transgenerational transmission of holocaust trauma. Lessons learned from the analysis of an adolescent with obsessive-compulsive disorder."

To what extent am I living in the reality of my mother's childhood – a childhood characterized by emotional loss, material deprivation and abuse? To what extent are some of my personality traits adaptive to my mother's childhood rather than mine? (It has been found that children of parents who struggle with unresolved loss may find themselves identifying with parental character traits produced by that experience.) To what extent have I recreated in my internal object world my mother's dead father? What we are talking about is the transposition of trauma across generations.

Can we possibly see encoded in my opening remarks at this session my grandmother's personal anxieties – transmitted to me intergenerationally – about estrangement from her homeland, social alienation, and her difficulties in communicating with English speakers in her adopted country? I had proposed that my therapist contact a psychoanalyst-social worker who might *translate* my psychoanalytic thoughts about my therapy sessions, as encapsulated in my letters, in a form comprehensible to my therapist, a social worker.

From a psychodynamic perspective, as I pointed out earlier, my proposal to my therapist can be seen in the following symbolic terms. I view the psychoanalyst as "self." The therapist (social worker) is non-self; the "psychoanalyst-consultant" is part-self and part non-self (both social worker and part psychoanalyst), and thus an "intermediate object" between self and non-self.

A *translator or interpreter* serves as an "intermediate object" between the speaker of one language and his conversational counterpart, the speaker of another language. The *translator or interpreter* speaks the language of both parties. With respect to both conversational partners, the *translator*

or *interpreter* is “part self” and part “non-self.” Can we *translate* my proposal to my therapist, namely, that she consult a psychoanalyst-social worker about me, into metaphorical terms in which I am saying: “I speak Polish (like my grandmother); you, the therapist, speak English. Could you consult an intermediate object (a psychoanalyst-social worker) who speaks both Polish and English and who could interpret my Polish-language writings in a form that would be comprehensible to you, the therapist (an English speaker)?

In concrete or literal terms the proposal I offered to the therapist concerned my therapy relationship with my therapist in the here-and-now. But in metaphorical (or desymbolized) terms we might say that perhaps I had encoded in the literal locution to my therapist a symbolic representation of my grandmother's anxieties about acculturation and alienation: that is, her anxieties about making herself understood to English speakers. Because of the therapist's literal or concrete thinking, she was blind to the psychodynamic implications of my proposal. She was blind to my possible internal psychic processes as *symbolized* in my proposal.

The therapist seems mired in objective reality, in objective truth. She ignores the existential dilemma of the human animal as expressed in Shengold's observation: *Man lives by metaphor; his mind is a poetry-making organ and a myth-making and history-making organ. Once past infancy, we have an intense need for psychic synthesis, continuity, and causality. We weave our memories [of real events, or objective reality] into narrative, from which we construct our identities . . .* That is to say, we live in a world of shared biological givens and objective truths, but we navigate that world through the lens of our inner myths: through the prism of our subjective and distinctly singular selves as encoded in a sector of the mind that lies outside conscious awareness.

The psychic importance for me of the “intermediate object” (or *translator*)

is clear when we examine a brief creative piece I wrote in the year 1990, twenty-eight years ago. The piece imagines an American who speaks only English who lives in a succession of villages in Albania. The American and the Albanians cannot communicate with each other; the American and the Albanians speak a different language. A Second American, who speaks both English and Albanian, serves as a *translator* or *interpreter* (an intermediate object), for his fellow American:

I.

An American moves to a small Albanian village. The American speaks only a few words of Albanian. None of the Albanians speak more than a few words of English. Relations between the Albanian villagers and the American are marginal. The Albanians view the American as aloof, cold, and strange. The negative interaction between the American and the Albanians is experienced as a torment by the American. Over a period of time the American internalizes the Albanians' negative view of him; he adopts the Albanians' view of him as his own view of himself. The American decides to leave the village and move to a second Albanian village.

II.

In the second village the American speaks only a few words of Albanian and none of the Albanians speak more than a few words of English. Again, relations between the American and the villagers are poor. But now, in addition to the problems posed by the American's language barrier he also bears the psychological scars he acquired in the first Albanian village. The American's problems are twofold, but interrelated. One difficulty is an interpersonal problem rooted in the conflict between his identity and the identity of the villagers (just as in the first village). A second difficulty is an intrapsychic conflict – with interpersonal effects – rooted in the internalization of the negative valuations to which he was subjected in the first village, a difficulty ultimately attributable to some degree to a conflict of identities. In a process analogous to the phenomenon of sympathetic

vibration, the American's interpersonal relations, to the degree they are mirrored in his intrapsychic functioning, produce "vibrations of the same period" in his introject.

A second American moves to the Albanian village; fortunately for him, the second American speaks Albanian fluently and gets on well with the local population. The first American strikes up a kind of friendship with the second American. (The two Americans do not necessarily read the same books, but the respective books they do read are written in the same language: a situation that gives rise to a rumor that our American friend is homospatial or, at least, has homospatial tendencies). The Albanian villagers, envious and angry that the American has made a friend, begin to spread a story that he is homospatial. The townspeople in the second Albanian village view the American not simply as aloof, cold, and strange, but as an aloof, cold, and strange homospatial. The American decides to move to a third Albanian village.

III.

In the third Albanian village, the American speaks only a few words of Albanian and the local Albanians speak no more than a few words of English. Again, relations between the Albanian villagers and the American are poor. But now, in addition to the problems posed by the American's language barrier and psychological scars, he is plagued by rumors that he is homospatial (that is, he has a marked tendency to think metaphorically of males whom he admires, integrating their contradictions into figures of speech). The rumors have been spread by contacts between residents of the second and third Albanian villages. Also, villagers from the first Albanian village, retaining their old vendetta against the American, provide information that confers a vogue of credibility to the rumors in the second and third Albanian villages.

What is the psychodynamic significance of the "intermediate object" for me? This seems to be an issue of psychodynamic importance.

(b.) False Self/True Self as They Relate to Schizoid and Narcissistic Tendencies

(It will be recalled that psychological testing disclosed statistically-significant schizoid and narcissistic trends in my personality.)

True self (also known as real self, authentic self, original self and vulnerable self) and false self (also known as fake self, idealized self, superficial self and pseudo self) are psychological concepts often used in connection with narcissism.

The concepts were introduced into psychoanalysis in 1960 by Donald Winnicott. Winnicott used *true self* to describe a sense of self based on spontaneous authentic experience, and a feeling of being alive, having a real self. The *false self*, by contrast, Winnicott saw as a defensive façade – one which in extreme cases could leave its holders lacking spontaneity and feeling dead and empty, behind a mere appearance of being real.

What I termed in my opening observations *my sense of alienation*, which I characterized as an internal state of alienation, or self-estrangement, can be seen as a product of a divided self that is torn, in Winnicott's terms, between a *True Self* and a *False Self*.

Similar terminology is employed to describe the dynamics of schizoid disorder. In schizoid pathology “[s]urvival is achieved by relating to the world with a partial self or 'false self,' one that is devoid of most significant affect and relates on the basis of conforming to others' requirements rather than on the basis of organismic experience [the True Self].” Yontef, G. “Psychotherapy of Schizoid Process.” Schizoid individuals fear a loss of self from being smothered, trapped, or devoured [*or engulfed*]. *Id.* “Instead of someone with a relatively cohesive sense of self interacting with others, there is a sense of self in which aspects of personality functioning are split off from each other. The most commonly

encountered manifestation of this in psychotherapy is the split between an attacking self and the ‘core’ or ‘organismic’ self. When the organismic self shows characteristics of being in need or emotional, the attacking self makes self-loathing, judgmental statements about being ‘weak’ or ‘needy.’ One might characterize this as attacking and shaming the organismic self, which it calls the ‘weak self.’ The person often identifies with the attacking self and thinks of his or her own love as so needy that it is devouring and humiliating. To the degree that the person’s contact is between parts of the self rather than a relatively unified self in contact with the rest of the person/environment field, the person is left with a deep and painful intimacy-hunger (often denied), dread, and isolation. The internal attack is usually not only on the self that is needy, hungry, and weak, but also on the self of passion and bonding—even happy passions.” *Id.*

When I speak of an internal sense of alienation I am speaking of a divided self, an internal state of self-estrangement, rather than a sense of isolation from others. In Yontef’s language, my True Self is split off (or alienated from) my False Self. There is no “communication” between these self fragments; each fragment “speaks his own language” and is incomprehensible to the other.

Kohut extended Winnicott’s work in his investigation of narcissism, seeing narcissists as evolving a defensive armor around their damaged inner selves. A child with absent, neglectful, or inconsistent caregivers who do not adequately *mirror* the child may foster the development of an adult who is *mirror hungry* and seeks out others (*mirroring selfobjects*) to facilitate a feeling of being centered, whole and complete. The *mirror hungry* individual, like Narcissus, seeks a merger between his idealized reflected image, as seen in the mirroring selfobject, and his injured self or damaged inner core.

I note that there is an underlying correspondence between Kohut’s

concept of selfobject needs – that is, an individual's need for alter-ego experience (twinship), idealization and mirroring – and Winnicott's concept of transitional objects, that is, “intermediate objects” that contain features of both self and non-self or, in the language of metaphor, a “translator” or “interpreter” who permits communication between two persons who speak different languages. Tamir, Y. “Adolescence, Facilitating Environment and Selfobject Presence: Linking Winnicott and Kohut's Self Psychology.”

In the twin fantasy the individual endows his daydream twin with all the qualities and talents that he misses in himself and desires for himself. Burlingham, D.T. “The Fantasy of Having a Twin.” All twin fantasies subserve multiple functions including gratification and defense against the dangers of intense object need. The twinlike representation of the object provides the illusion of influence or control over the object by the pretense of being able to impersonate or transform oneself into the object and the object into the self. Intense object need persists together with a partial narcissistic defense against full acknowledgment of the object by representing the sought-after object as combining aspects of self and other. Coen, S. and Bradlow, P.A., “Twin Transference as a Compromise Formation.” The identical alter ego or twin is a derivative of the infant's mirror stage which states the necessity of identifying with an external image in order to develop an ego; I must identify as “I” that which is not me. Faurholt, G. “Self as Other: The Doppelgänger.”

While the transitional object, such as a teddy bear, is endowed by the child with the qualities he lacks and takes on the characteristics of his idealized object relationship; the child in a sense becomes identified and nurtured with the characteristics of his own idealized object relationship. The transitional object helps the child feel a sense of cohesion in the self, as well as a temporal coherence from the past to the present. Roig, E. “The Use of Transitional Objects in Emotionally Disturbed Adolescent Inpatients.” Winnicott proposed a developmental trajectory stemming

from the infant's initial use of such a transitional object, dually vested as both an element of the external world and an illusory creation of imaginative inner life. Throughout life, this trajectory extends to other transitional phenomena such as imaginative play, meaningful expression of self through work, and all creative aspects of adult life. At their origin, these transitional phenomena involved "the use of objects that are not part of the infant's body yet are not fully recognized as belonging to external reality." According to this theory, these intermediate areas of experiencing offer "a resting place for the individual engaged in the perpetual task of keeping inner and outer reality separate yet inter-related." Harrison, R.L. "Scaling the Ivory Tower: Engaging Emergent Identity as Researcher."

I note, incidentally, that possibly related to twin fantasy/transitional object phenomena is the so-called "secret sharer" fantasy in which two creative adults influence each other through collaboration; they write for each other and *share an unconscious fantasy* of creating together in a sublimated sexual act. The secret sharer fantasy is a narcissistic one in which the double often represents the mother of early infancy with whom one merges and creates. It is also Oedipal in that in fantasy the relationship spawns a product – unconsciously a baby. The Oedipal attachment might be of the negative or positive type. Glenn, J. "Robert Frost's 'The Road Not Taken' Childhood, Psychoanalytic Symbolism, and Creativity." At a time in his life when he was planning to go to law school (September 1990), my friend Craig said to me: "Maybe we could practice law together. We could form our own firm and be law partners." Was that perhaps an expression of a "secret sharer" fantasy? Early in his career Freud formed a close friendship with an ear, nose and throat specialist named Wilhelm Fliess; in a voluminous correspondence Freud and Fliess shared psychological theories and Freud submitted his dreams to Fliess that he would later publish in his book, *The Interpretation of Dreams*. Freud and Fliess were "secret sharers;" perhaps their collaboration could be termed a transitional phenomenon.

We should recognize that symbolically encoded in my concrete proposal to the therapist that she contact a “psychoanalyst-social worker consultant” who might facilitate the therapist's understanding of my psychological needs, we can find both *selfobject longing* (that is, my longing for another person who sees the world as I see it and who would thereby satisfy my need for *selfsameness*) and my need for a *transitional object* who would combine aspects of both self (that is, someone who would understand my capacity for symbolization and my preoccupation with my mental interior: namely, a psychoanalyst) and non-self (that is, a social worker who is concerned with social adjustment) and thereby facilitate my therapist's understanding of me and ultimately promote my sense of well-being, wholeness and completeness. The therapist focused on why and how such a course of action, as a practical reality, would help me. She should have focused on what the proposed action meant for me subjectively: what were the anxieties that drove this proposal, which was no doubt defensive in nature.

I am saying that the literal reality that prevailed between the therapist and me during our opening clinical exchange masked my underlying psychological needs, whether you choose to see those needs as legitimate or defensive. The therapist's concrete thinking blocked her ability to go beyond the reality situation presented at the beginning of the session; she was unable to read the underlying “poetry” (or symbolic content) of my opening communication that centered on unexpressed *mirror hunger* or *alter-ego* needs and the lack of satisfaction of those needs.

What also emerged at this session was a glaring example of the therapist's inability to think about the context of my communications, both within a session and from session to session. A psychodynamic therapist might have recognized that the patient who talked about his desire for a facilitating “psychoanalyst-social worker consultant” at this session was the very same patient who for several past weeks talked about his idealizing

obsession with his former primary care doctor; you will recall that my obsession with my primary care doctor was grounded in my selfobject needs, namely, my *mirror hunger* and my need for alter-ego experience and idealization, or selfsameness. The therapist's cognitive limitation (her concrete thinking) and her non-psychodynamic theoretical orientation (her reluctance to look at inner processes) rendered her oblivious to the psychological meanings underlying my overt words and actions. As such, the therapist disclosed a failure of empathy.

We are justified in saying that while I am preoccupied with the *symbolic* and the *internal* (or psychic), the therapist is mired in the *literal* (concrete) and the *external*, that is, the world of interpersonal relationships or external object relations. For the therapist, "things are the way she believes them to be." For me, things contain a multiplicity of meanings that need to be – *interpreted*.

(c.) Transitional Experience

When I speak of an “intermediate object” that lies in the space between self and non-self – like a *translator* or *interpreter* who facilitates communication between two persons who speak different languages – am I not also talking about the “transitional object?”

A comfort object, transitional object, or security blanket is an item used to provide psychological comfort, especially in unusual or unique situations, or at bedtime for children. Among toddlers, comfort objects may take the form of a blanket, a stuffed animal, or a favorite toy, and may be referred to by nicknames.

Winnicott introduced the concepts of "transitional objects" and "transitional experience" in reference to a particular developmental sequence. With "transition" Winnicott means an intermediate developmental phase between the *psychic* and *external reality*. In this

"transitional space" we can find the "transitional object."

When the young child begins to separate the "me" (self) from the "not-me" (non-self) and evolves from complete dependence to a stage of relative independence, it uses transitional objects. Infants see themselves and the mother as a whole. In this phase the mother "brings the world" to the infant without delay which gives it a "moment of illusion," a belief that its own wish creates the object of its desire which brings with it a sense of satisfaction. Winnicott calls this *subjective omnipotence*. Alongside the subjective omnipotence of a child lies an objective reality, which constitutes the child's awareness of separateness between itself and desired objects. While the subjective omnipotence experience is one in which the child feels that its desires create satisfaction, the objective reality experience is one in which the child independently seeks out objects of desire. (I am reminded of something my friend Craig once said to me: "I generally don't make an effort to be friendly with people. I wait for people to come to me." (August 1987).

Later on the child comes to realize that the mother is a separate entity, which tells the child that he has lost something. The child realizes that he is dependent on others, thus losing the idea that he is independent. This realization creates a difficult period and brings frustration and anxiety with it. The mother cannot always be there to "bring the world" to the baby, a realization which has a powerful, somewhat painful, but ultimately constructive impact on the child. *Through fantasizing about the object of its wishes the child will find comfort.* A transitional object can be used in this process. The transitional object is often the first "not me" possession that really belongs to the child. This could be a real object like a blanket or a teddy bear, but other "objects", such as a melody or a word, can fulfill this role as well. This object represents all components of "mothering," and it means that the child itself is able to create what it needs as well. It enables the child to have a fantasized bond with the mother when she gradually separates for increasingly longer periods of time. The transitional object is

important at the time of going to sleep and as a defense against anxiety.

When I proposed to the therapist that she contact a psychoanalyst-social worker about me (an individual who represented for me an intermediate object that combined elements of self and non-self) was I not fantasizing about *the object of my wishes* just as the young child fantasizes about “the object of his wishes” (that combines elements of self and non-self) by means of his transitional object?

At a previous session I had discussed with the therapist Winnicott's concept, “the capacity to be alone.” Winnicott, who theorized that in order to learn to be alone, free, and able to play spontaneously, an individual must first have the paradoxical experience of being alone in the presence of a good enough other. Winnicott believed that an individual's capacity to enjoy solitude is an important element of emotional health and maturity, which, paradoxically, is first developed in relationship to the presence of a reliable other. He suggested one first learns to be at ease with oneself (and sufficient unto oneself) in the presence of a well-boundaried, dependable, and sensitively responsive person. This kind of other does not engage in surveillance or monitoring, but rather mirrors and reflects the experiences of the developing individual without intruding on his solitude.

A later strand of analysis, drawing on the work on listening of Theodore Reik, has emphasized the importance of the therapist's capacity to be alone in the therapy situation – to remain centered in themselves in the face of the projections and resistances of the patient (something this therapist seems to have a problem doing). Indeed, at that earlier session where I referenced the capacity to be alone, I told the therapist that I viewed the exploratory work of psychodynamic therapy – which emphasizes the patient's immersing himself in his inner world – as being related to the child's ability to occupy himself with his own thoughts and fantasies in the presence of a non-intrusive mother.

Is my desire for psychodynamic therapy an expression of my need to consciously convey my inner wishes and fantasies in an exploratory psychodynamic context in which the therapist serves as a facilitator of my creative communications rather than as an *external impingement* – just as the secure child needs the nonintrusive mother to facilitate his capacity to be alone? Do I view the psychodynamic therapist as one who would mirror and reflect my experiences and feeling states without intruding on my exploratory reverie.

Is my perceived need for an intermediate object (a “translator” or “interpreter” or transitional object) somehow related to my need for a therapist who will facilitate the growth of my potential to experience and convey my True Self – that is, an intermediate object who will *translate* the recondite fantasies and wishes of my True Self (a subjective and distinctly singular self) that are encoded in that sector of my mind that lies outside conscious awareness and that emerge in conscious awareness only as symbolized constructions?

I am attracted to the idea that psychodynamic therapy constructs in the clinical situation a framed, transitional area in which the patient's inner world can find expression. The patient creates and recreates unconscious processes, and presents these in a manner which resonate with the therapist's shared sense of symbols. By articulating these shared symbols, the patient invites the therapist into this intermediate area of experiencing. The patient chooses symbols and images of a common language, and finds comfort not available in himself. He invites the therapist into this in-between space, beyond the merely private, subjective, or psychological, which serves as a resting place between inner and outer reality, between psyche and language. In this way, psychodynamic therapy is like the child's experience in imaginative play. Such a view of psychotherapy requires a therapist who has a capacity for symbolization (that is, a capacity to see the metaphoric meaning behind the literal) and a

willingness to acquiesce in the patient's idiosyncratic symbol making: speaking metaphorically, a capacity to recognize that the patient's "play-dough" – literally, a concoction of flour and water – is not simply a concoction of flour and water, but has symbolic meaning as, for example, a snowman or an octopus. Cf. Praglin, L. "The Nature of the 'In-Between' in D.W. Winnicott's Concept of Transitional Space and in Martin Buber's *das Zwischenmenschliche*."

APPENDIX TO THERAPY SESSION: OCTOBER 2, 2018

Years ago I had a dream about my friend Craig that seemed to symbolize both Kohut's ideas about selfobject needs and Winnicott's ideas about transitional objects.

Upon retiring on the evening of Friday July 1, 1994 I had the following strikingly brief and simple dream:

Dream of the Blue Oxford

I am looking at a man's shirt; it is blue with a buttoned-down collar. I know intuitively that the shirt belongs to my friend Craig. There is no objective evidence that the shirt belongs to Craig, however. I look at a tag affixed to the shirt that indicates its size. I see that the collar measures 15-1/2" and the sleeve measures 33", which is my shirt size. I feel a great deal of satisfaction to learn that Craig and I wear the same size shirt. I have an impulse to smell the shirt. At that moment I think: "Only a queer would smell another guy's shirt." I examine the collar of the shirt and notice that it is frayed in one location.

EVENTS OF THE PREVIOUS DAY, July 1, 1994: I watch the televised preliminary hearing in the O.J. Simpson murder case. On this day of the hearing the prosecution attempts to establish the approximate time of death of the victims, who were killed in a knife attack.

EVENTS OF JULY 1, 1976: My father dies one day after having undergone a coronary artery bypass, a surgical procedure. On the evening of July 1, 1976 my mother gathers together a suit, necktie and shirt for my father's burial. She wants to bury him in a white shirt, but my father does not own a suitable white shirt. My mother asks me if I will give her a white shirt that I own, which I do. I had worn the shirt on only one previous occasion. Thus, my father was laid to rest attired in my white shirt.

The manifest dream can be interpreted as an expression of my twinship or alter ego needs using terms from Kohut's self psychology in that the dream imagines that Craig and I are physically similar; we wear the same size shirt. Our physical likeness symbolizes my sense of selfsameness with him.

In Kohut's framework, selfobjects are external objects that function as part of the "self machinery" - "i.e., objects which are not experienced as separate and independent from the self." They are persons, objects or activities that "complete" the self, and which are necessary for normal functioning. Kohut describes early interactions between the infant and his caretakers as involving the infant's "self" and the infant's "selfobjects." In thinking about the psychic meaning of the dream I associated to the court testimony of a witness in the O.J. Simpson murder case.

The witness, Steven Schwab testified that he found a stray dog one night while walking his own dog. The agitated lost dog had no identifying tag ("no identity") and seemed to frantically want to communicate something. The dog might be said to need a "translator" who would understand its panicked state. Such a "translator" would be an intermediate object or "courier" between the dog and potential rescuers. Perhaps we may say that Schwab served as that intermediate object who, over the course of the following hours, unraveled the dog's secret; Schwab interpreted the dog's

seeming need to communicate a message.

In a second association I thought about Jan Karski, a Polish World War II resistance-movement soldier who served as a “courier” or *intermediate object* between the Warsaw ghetto’s Jewish inhabitants during World War II and the Polish government-in-exile in London. It was Karski’s role as courier or *intermediate object* to communicate the desperate plight of the Warsaw ghetto Jews to the outside world, paralleling the role of Schwab in the O.J. Simpson case who brought the stray dog’s desperate message to the attention of the authorities.

How do my associations to Schwab and Karski, two individuals who served as *intermediate objects* who communicated a message from mute victims to the outside world, correspond to the manifest dream image of a shirt owned by my alter ego friend? Might we say that Schwab and Karski symbolized a transitional space between my silent inner world (the unconscious) and the world of external objects: an *intermediary* between the inner world of fantasy and the outer world of sensory impingement? Note that Winnicott attaches importance to the *smell* and *texture* of the transitional object. Remember the following thought in the manifest dream: *I have an impulse to smell the shirt.*

“The child sucks their thumb and takes an external object such as a blanket, part of a sheet, a handkerchief or napkin (diaper or nappy) into the mouth using the other hand. The child then sucks the cloth or **smells it** or rubs it against the cheek. The texture and **smell** are important.”
The teddy bear (as a transitional object) as well as the shirt of the manifest dream are cloth objects – objects in which **texture** is important.

First Association: Steven Schwab Testimony

The following is a partial transcript of the testimony of Steven Schwab, called as a witness in the O.J. Simpson preliminary hearing on July 1, 1994. The witness is wearing a white suit, dark tie—and a blue shirt with a buttoned-down collar.

[Clerk]: State and spell your name for the record.

[Witness]: My name is Steven Schwab. S-T-E-V-E-N S-C-H-W-A-B.

[The issue of identity is overdetermined in the text. Schwab is called to identify himself in court, that is, state his name. Schwab thereafter describes an *unidentified dog* that has no tags: no name. With transitional phenomena, a concrete object transitions into abstraction: the teddy bear assumes the *identity* of self and mother perceived as non-self. This is an interim region between fantasy and reality. This potential space is what Winnicott viewed as play, an infinite intermediate area where external and internal reality are amalgamated. Correspondingly, this is a territory in which the subject can take on the *identity* of a fictional character interlaced with his own identity without fear or retaliatory consequences. It is through this play that one can explore and perceive self and his relation to others. Perhaps, we might venture to say that the unidentified dog symbolizes the infant, who has no autonomous self. The unidentified dog exists in a merged state with the owner, just as in the infant's subjective world it is one with the mother. The *nameless* dog symbolizes the infant who has no sense of "I." At the earliest stage of development, the infant does not distinguish between self and non-self, between "I" and "she." It is in the transitional stage, or intermediate stage, that the infant begins to develop a sense of self as an autonomous "I."]

[Court]: You may inquire.

[Prosecutor]: Thank you, your honor. Good morning, Mr. Schwab.

[Witness]: Good morning.

[Prosecutor]: Directing your attention, sir, to the date of June 12th, 1994, Sunday, as of that date, sir, can you tell us where you lived?

[Witness]: I live on Montana Avenue. Do I need to give the address?

[Prosecutor]: No, sir, you don't. Was that on Montana near to Bundy?

[Witness]: Yes. That's on Montana between Bundy and San Vicente.

[Prosecutor]: How far from the intersection of Bundy and San Vicente did you live at that date?

[Witness]: It's about half a block.

[Prosecutor]: Do you own any pets, sir?

[Witness]: Yes, I have two pets. I own a dog and a cat.

[Prosecutor]: Do you ever walk the dog in that neighborhood?

[Witness]: Yes, I walk the dog in that neighborhood, in the morning and at night.

[In drive theory, a group of daydreams, the animal fantasies of the latency period, originate as a result of the same emotional conditions that are the basis for the so-called twin fantasies. Burlingham, D. "The Fantasy of Having a Twin." The child takes an imaginary animal as his intimate and beloved companion; subsequently he is never separated from his animal friend, and in this way he overcomes loneliness. This daydream is constructed in much the same way as the twin fantasy, with this

difference: the child chooses a new animal companion who can understand him in his loneliness, unhappiness, and need to be comforted. In drive theory, animal fantasies and the fantasy of having a twin sibling are related fantasies, oedipal in origin, of the latency period.]

[Prosecutor]: With regard to at nights, is that a habit that you have, sir, of doing that every night?

[Witness]: Yes. I walk the dog every night after watching television.

[Prosecutor]: Is there a particular time that you always walk the dog at nights?

[Witness]: There . . . It varies from day to day, because of the different shows that are on, generally, during the week I walk at a different hour than on the weekends.

[Prosecutor]: During the week, what time do you usually walk the dog at night?

[Witness]: I usually leave the house at 11:30. That's during the week. I generally watch the Dick Van Dyke Show, and then walk my dog, and that's during the week. That's on between 11:00 and 11:30.

[Prosecutor]: And on Sunday nights?

[Witness]: Well, the Dick Van Dyke Show is also on, but it's on an hour earlier. So, I watch the Dick Van Dyke Show on Sunday night-I watch it between 10:00 and 10:30. And then I go to walk my dog.

[Prosecutor]: Now, June the 12th was a Sunday, sir?

[Witness]: Yes, it was.

[Prosecutor]: Did you watch the Dick Van Dyke Show that night?

[Witness]: Yes, I did.

[Prosecutor]: And that was at what time you watched that show?

[Witness]: I watch the show between 10:00 and 10:30.

[Prosecutor]: Did you watch the entire show, sir?

[Witness]: Yes, I did.

[Prosecutor]: And what time did that show end?

[Witness]: That ends just prior to 10:30.

[Prosecutor]: Did you walk your dog that night after you watched the show?

[Witness]: Yes, as soon as the show was over, I got my dog, put her leash on, and took her for a walk.

[Prosecutor]: So, on the night of June the 12th, that Sunday night, about what time did you leave your apartment to walk your dog?

[Witness]: Shortly after 10:30. Between 10:30 and 10:35. Much closer to 10:30, though.

[Prosecutor]: Can you tell us what route you took when you walked her?

[Witness]: Yes, I walked down Montana, and I continued along Montana, I crossed the street at the intersection of Montana and Bundy and

continued along Montana until I got to a street called Gretna Green. At Gretna Green I made a left and walked up one block, made a right on a street called Gorham, I then walked down one block, made a left on Amherst, walked up one block to Amherst and Dorothy, made a left at Amherst and Dorothy, and continued along Dorothy until I came to Bundy.

[Prosecutor]: Now, if you can tell us. You walked along Montana past Bundy, and you went left on Gretna Green?

[Witness]: Yes.

[Prosecutor]: How long did it take you to get to Gretna Green?

[Witness]: Well, I looked at my watch, when I turned to go down Gretna Green and that was 10:37. I remember that my dog had taken care of its business. I was deciding whether to return home or continue walking. And it was a nice night, so I decided to continue walking.

[Prosecutor]: Sir, what time was it about when you got to Gretna Green?

[Witness]: 10:37.

[Prosecutor]: 10:37 - You know that exactly?

[Witness]: Well, between 10:35 and 10:40. Obviously, it's not exact because I don't have a digital watch. But it was between 10:35 and 10:40.

[Prosecutor]: Were you wearing a watch at all?

[Witness]: Yes, I was wearing a watch.

[Prosecutor]: A regular watch, not the digital kind?

[Witness]: Not the digital. In fact, I'm wearing it now. It's a regular watch.

[Prosecutor]: Can you tell us what kind of watch that is?

[Witness]: Sure. [Witness displays watch.] It's a regular watch. It doesn't have numbers on the face. It's not a digital watch.

[Prosecutor]: For the record, the witness is indicating a watch that has dots where the hours would be . . .

[Court]: All right.

[Prosecutor]: An analog watch.

[Prosecutor]: So, at what street did you decide to turn around and go back home?

[Witness]: Well, that was when I came to Amherst and Dorothy. At Amherst and Dorothy I made a left, which would take me back home. I use this route . . . This takes me, generally, half an hour to do because I get home and then another show begins at 11:00 and 11:30. So, that's the route I use.

[Prosecutor]: So, you turned around at Amherst and Dorothy and decided to go back home.

[Witness]: Correct.

[Prosecutor]: What happened next?

[Witness]: Well, I was walking down Dorothy and as I approached the corner of Dorothy and Bundy, I saw that there was a dog at the corner of

Dorothy and Bundy, I saw that there was dog at the corner. It was a large Akita, very white, and as I approached further I saw that it wasn't with anyone. There was no one walking the dog. The dog was just there. And, the dog . . . It was unusual for a dog to just be wandering the neighborhood by itself. And the dog seemed agitated. It was barking at the house on the corner.

[Prosecutor]: On the corner of what?

[Witness]: On the corner of Dorothy and Bundy. There's a house on the corner that has a driveway that . . . a path to the door—that comes right to the corner. And it was unusual for a dog to be barking at a home that way. But that's what it was doing. And . . .

[Prosecutor]: Can you describe the way the dog looked?

[Witness]: Yes. It was a white Akita. Beautiful dog. It had a collar on, what looked like a very expensive embroidered collar—red and blue.

[Schwab's discussion of the dog's collar seems to parallel the dream thought concerning the frayed collar: "I examine the collar of the shirt and notice that it is frayed in one location."]

[Witness]: Um, and it smelled my dog and my dog smelled it.

[Note the issue of smell and its possible relation to the role of smell in transitional objects.]

[Witness]: And I looked . . . I checked the collar to see if there was an address or a tag on it. But there wasn't.

[Schwab's statement regarding a possible dog tag or other identifier seems to parallel the following dream thought: "I look at a tag affixed to the shirt

that indicates the size of the shirt. I see that the collar measures 15-1/2" and the sleeve measures 33", which is my shirt size. I feel a great deal of satisfaction to learn that Craig and I wear the same size shirt."

It is significant that the theme of inquiry into identity recurs in the hearing transcript. The witness's inquiry into the identity and origin of the dog ("I checked the collar to see if there was an address or a tag on it") parallels the later courtroom examination of the witness himself, who was asked *pro forma* by the Court to state his name, and, by the prosecutor, to state his address. The witness's later description of his discovery of blood on the dog's paws points to some unidentified victim. An issue of personal identity attaches to three figures in the hearing transcript: the witness (Schwab), the unidentified dog, and the unknown putative victim. Thus, the theme of personal identity emerges in various guises in the testimony.]

[Witness]: So, I didn't know where the dog was from. And as I examined the dog further, I noticed that there was blood on the paws.

[Prosecutor]: Blood on all four paws?

[Witness]: There seemed to be blood on all of the paws in different amounts. There was more on some than on others. But there was blood on the paws. I specially, I noticed some blood on one of the back paws. That was the one I noticed first.

[Prosecutor]: Now, what time was it when you first saw that dog?

[Witness]: Well, I didn't look at my watch the moment that this occurred. But based on the path and how long it generally takes me, I would say that that was approximately 10:55.

[Prosecutor]: And that was at the corner of Dorothy and Bundy?

[Witness]: Yes, it was.

[Prosecutor]: Did the dog wear a leash?

[Witness]: No, there was no leash. There was just the collar.

[Prosecutor]: The blood that you saw on the dog's paws, did it appear to be wet, fresh or dry?

[Witness]: I didn't touch the blood, so I don't really know. The dog was also dirty, and there seemed to be mud on the dog. But, um, I didn't get like any blood on my hands or anything like that, so I don't know whether it was wet or dry.

[Prosecutor]: After those two dogs met each other, what happened next?

[Witness]: Well, my dog doesn't like other dogs very much. They barked at each other for a little bit. And then I noticed by that time that no one had come that wasn't like a block or two behind that, you know, in front of its owner or anything. So, I crossed the street at that point. I crossed the street from one side of Bundy to the other. And the dog stayed with us. The dog followed us, and, ah, so knowing that this was a lost dog I allowed it to stay with us. And I continued. . . I made a left at that point on Bundy heading back towards my house.

[Prosecutor]: During the time that the dog walked with you, did it continue to bark?

[Witness]: Yes, it was very strange. It would bark at each house as we passed. It would bark at. . . When we got to the entrance to the house, the path leading to the door of the houses, it would bark at the house. I had never seen anything like that before. But it would stop at each house and

bark.

[Prosecutor]: So, as you walked down the sidewalk, you and your dog. The other one was following you. And every time you got to a place where a path leading up to a residence met the sidewalk, the dog would stop, look at the house, and bark.

[Witness]: Yes, absolutely. But the dog also didn't want to get very far from myself and my dog. It stayed very, very close to us.

[Witness]: Well, I continued to walk down Bundy and at that point, ah, a police car came, going in the other direction. And so I flagged the police car down to tell him that I had found this dog. And I did. I told the officer that I had found this dog that's obviously lost, and that maybe he could, you know, call someone, find out if someone had reported a missing dog. And he said he would take care of it. And so I continued on, but the dog continued to follow me. And it followed me down Bundy past Gorham, again, and then, all the way to Montana. So, I turned the corner on Montana. I made a right on Montana heading home, and the cop pulled into a driveway on Montana heading home, and the cop pulled into a driveway on Montana and we spoke again because obviously the dog wasn't going to leave my side. So, at that point I gave him my address and the phone number and said that I would take the dog home and that he would call the animal control people, and that they would contact me with regard to the dog. So, I left the police officer at that time, continued home, and the dog followed me into the courtyard of my building, which has a pool, and up the stairs-I live on the second floor-up the stairs into my apartment. I mean, it stayed right with me. At that point I went into the house, leaving the dog outside because my wife was inside, and I also have a cat. And I didn't want to freak either of them out. So I closed the door and told my wife that this big Akita followed me home.

* * * *

[Witness]: At that point while we were discussing the various options my neighbors came home. And . . .

[Prosecutor]: Can you tell us what their names were?

[Witness]: Yes. His name is Sukru and her name is Bettina. And they live.

. . .

[Prosecutor]: What time was it when you saw them?

[Witness]: That would have been, oh, about 11:40.

[Prosecutor]: At the time that they came into the apartment building, were you outside still?

[Witness]: Yes, we were out in the courtyard. And we were discussing whether it would be OK if maybe we could tie the dog up in the courtyard overnight 'cause my plan was to tie the dog up or keep the dog with us overnight and then print up some posters on my computer, go back to the location, put up lost dog signs, and try to find the owner.

[Prosecutor]: So, you were outside in the courtyard with your wife and the dog. . .

[Witness]: And the dog, absolutely.

[Prosecutor]: . . . when Sukru and Bettina came up.

[Witness]: That's exactly what happened. And Sukru and Bettina take care of my dog when I'm away, either on vacation or if I'm out of town for the weekend, they take care of my animals. And, um, so, at that point Sukru

offered to take care of the dog overnight and to leave it out in the courtyard in the morning so that in the morning I could deal with trying to find the owner once again.

[Prosecutor]: And, did you give him the dog?

[Witness]: At that point I gave him the dog. And, I said, "fine." And at that point he took the leash that I had put on the dog—it was still on the dog—he took the dog for a walk. My wife and I spoke to his wife, Bettina, for a few more minutes and then went to bed.

[Prosecutor]: And did you ever see the dog again after that?

[Witness]: I have not seen the dog again since then. That was the last that I saw of the dog.

[Prosecutor]: Thank you. I have nothing further.

Second Association: Jan Karski Testimony

According to psychoanalyst Stanley Greenspan "every dynamic drama must take place in the context of a particular structure or set of structures. In addition, when focusing on structural perspectives it's [important to recognize] that structures provide the foundation—the housing, so to speak—for different dynamic dramas, each with its own content or meanings." "A Conversation with Stanley Greenspan." *The American Psychoanalyst*, 28(3): 25-27, 26 (1994).

I have identified a text the structure of which is identical to that of the earlier Schwab text.

The text is a portion of the transcript of the 1985 French film *Shoah*. The film, produced by Claude Lanzmann, comprises a collection of interviews of Nazi holocaust survivors, Nazi officials, and other eyewitnesses of the holocaust. The text in question is a transcript of an interview of Jan Karski, a former courier of the Polish government-in-exile in London who was enlisted by underground Jewish leaders in Poland to inspect the Warsaw ghetto and report his observations to the Allied governments. See Lanzmann, C. *Shoah: Transcription of English Subtitles to 1985 French Film Shoah* at 167-175 (New York: Pantheon Books, 1985).

The key figures in the text are (1) the interviewer (an intellectualized, or affectively neutral, figure), (2) Jan Karski (*an intermediate object*), (3) the underground Jewish leaders (frantic witness-participants), and (4) inhabitants of the ghetto (mute victims).

These key figures parallel the central figures of the Schwab testimony, who comprise (1) the prosecutor (an intellectualized, or affectively neutral, figure) who examines (2) Steven Schwab (*an intermediate object*), (3) the dog Kato (a frantic witness-participant), and (4) the mute victims.

I am intrigued by the possibility that it was not the content of the Schwab testimony alone that instigated the dream, but also the housing of that content: namely, the structure of the Schwab testimony. That structure may be interpreted to symbolize the differentiated or contradictory mental states of a *single individual*: integrated representations of thought and feeling of a single individual as projected onto a "gallery of characters" – in such a figurative sense, Schwab and Karski would each respectively represent the "I" of a single person, while the other figures in the text would assume the role of "he," a situation that would prevail in the vertical splitting of a single person.

"The existence of the complicated split mental representations of self and parents does not automatically make for pathology," explains Shengold.

"That depends on how the splits are used. The crucial questions are whether the contradictory mental representations can be integrated if necessary, and whether they can be brought together and taken apart again so that they can be worked with in a flow of thought and feeling."
See Shengold, L. *Soul Murder* at 280-281 (New Haven: Yale University Press, 1989).

The structure of the Schwab testimony (and that of the Shoah narrative) may be interpreted to symbolize aspects of ego structure and functioning:

- a split between observing and experiencing egos (vertical splitting);*
- a differentiated ego structure that houses, or accommodates, valences of thought and feeling arrayed in layered gradations;*
- an ego that has developed the capacity to permit inquiry (as denoted in the judge's opening direction in the Schwab testimony, "You may inquire"). "This, in Kleinian theory, would be the equivalent of the movement into the depressive position, where there is a loss of omnipotent phantasy and the relinquishment of omniscience in favor of curiosity, and a capacity for inquiry as well as a capacity to live in time and endure the contradictory and opposing experiences of hatred and love." Zeavin, L., "Bion Today" (Book Review).*

I had seen the eight-hour movie *Shoah* in a television broadcast in about 1987 or 1988. In my recollection the many interviews presented in the film merged into a vague sameness, except for one (which apparently held some special meaning for me), the interview of -

Jan Karski, university professor (USA), former courier of the Polish government in exile:

Now . . . now I go back thirty-five years. No, I don't go back . . . I come

back. I am ready.

In the middle of 1942, I was thinking to take up again my position as a courier between the Polish underground and the Polish government in exile in London.

[The reference to the "government-in-exile" may be interpreted, psychoanalytically, to relate to the Family Romance fantasy, with the Nazi occupiers of Poland representing a debased parental image, and the Polish government-in-exile in London representing an idealized parental image, endowed in fantasy with a rescuer role. In drive theory, the latency age child's animal fantasies as well as the fantasy of having a twin sibling originate as a result of the same emotional conditions (oedipal conflicts) that are the basis for the so-called *family romance* wherein the child develops fantasies of having a better and worthier family than his own, which has so bitterly disappointed and disillusioned him. Burlingham, D.T. "The Fantasy of Having a Twin." Perhaps, we may say that in the *family romance* the child imagines that his biological parents are non-self ("These people are not my real, biological parents. They are illegitimate imitators."), while the child's imagined ideal parents assume the status of self ("I must be the child of ideal, special parents. These special people of my imagination are my legitimate parents.") The Polish resistance during world War II viewed the Polish Government-in-Exile in London as the legitimate government, while the government apparatus in Poland was viewed as illegitimate.]

The Jewish leaders in Warsaw learned about it. A meeting was arranged, outside the ghetto. There were two gentlemen. They did not live in the ghetto. They introduced themselves--leader of Bund, Zionist leader.

Now, what transpired, what happened in our conversation? First, I was not prepared for it. I was relatively isolated in my work in Poland. I did not see many things. In thirty-five years after the war I do not go back. I

have been a teacher for twenty-six years. I never mention the Jewish problem to my students. I understand this film is for historical record, so I will try to do it.

They described to me what is happening to the Jews. Did I know about it? No, I didn't. They described to me first that the Jewish problem is unprecedented, cannot be compared with the Polish problem, or Russian, or any other problem. Hitler will lose this war, but he will exterminate all the Jewish population. Do I understand it? The Allies fight for their people—they fight for humanity. The Allies cannot forget that the Jews will be exterminated totally in Poland—Polish and European Jews. They were breaking down. They paced the room. They were whispering. They were hissing. It was a nightmare for me.

Did they look completely despairing?

Yes. Yes. At various stages of the conversation they lost control of themselves. I just sat in my chair. I just listened. I did not even react. I didn't ask them questions. I was just listening.

They wanted to convince you?

They realized, I think . . . they realized from the beginning that I don't know, that I don't understand this problem. Once I said I will take messages from them, they wanted to inform me what is happening to the Jews. I didn't know this. I was never in a ghetto. I never dealt with the Jewish matters.

Did you know yourself at the time that most of the Jews of Warsaw had already been killed?

I did know. But I didn't see anything. I never heard any description of what was happening and I was never there. It is one thing to know

statistics. There were hundreds of thousands of Poles also killed—of Russians, Serbs, Greeks. We knew about it. But it was a question of statistics.

Did they insist on the complete uniqueness . . . ?

Yes. This was their problem: to impress upon me—and that was my mission—to impress upon all people whom I am going to see that the Jewish situation is unprecedented in history. Egyptian pharaohs did not do it. The Babylonians did not do it. Now for the first time in history actually, they came to the conclusion: unless the Allies take some unprecedented steps, regardless of the outcome of the war, the Jews will be totally exterminated. And they cannot accept it.

This means that they asked for very specific measures?

Yes. Interchangeably. At a certain point the Bund leader, then at a certain point the Zionist leader—then what do they want? What message am I supposed to take? Then they gave me messages, various messages, to the Allied governments as such—I was to see as many government officials as I could, of course. Then to the Polish government, then to the President of the Polish republic, then to the international Jewish leaders. And to individual political leaders, leading intellectuals—approach as many people as possible. And then they gave me segments—to whom do I report what. So now, in these nightmarish meetings—two meetings—two meetings I had with them—well, then they presented their demands. Separate demands. The message was: Hitler cannot be allowed to continue extermination. Every day counts. The Allies cannot treat this war only from a purely military strategic standpoint. They will win the war if they take such an attitude, but what good will it do to us? We will not survive this war. The Allied governments cannot take such a stand. We contributed to humanity—we gave scientists for thousands of years. We originated great religions. We are humans. Do you understand it? Do you understand it?

Never happened before in history, what is happening to our people now. Perhaps it will shake the conscience of the world.

We understand we have no country of our own, we have no government, we have no voice in the Allied councils. So we have to use services, little people like you are. Will you do it? Will you approach them? Will you fulfill your mission? Approach the Allied leaders? We want an official declaration of the Allied nations that in addition to the military strategy which aims at securing victory, military victory in this war, extermination of the Jews forms a separate chapter, and the Allied nations formally, publicly, announce that they will deal with this problem, that it becomes a part of their overall strategy in this war. Not only defeat of Germany but also saving the remaining Jewish population.

* * * *

Between those two Jewish leaders—somehow this belongs to human relations—I took, so to say, to the Bund leader, probably because of his behavior—he looked like a Polish nobleman, a gentleman, with straight, beautiful gestures, dignified. I believe that he liked me also, personally. Now at a certain point, he said: "Mr. Vitold, I know the Western world. You are going to deal with the English. Now you will give them your oral reports. I am sure it will strengthen your report if you will be able to say 'I saw it myself.' We can organize for you to visit the Jewish ghetto. Would you do it? If you do, I will go with you to the Jewish ghetto in Warsaw so I will be sure you will be as safe as possible."

A few days later we established contact. By that time the Jewish ghetto as it existed in 1942 until July 1942 did not exist anymore. Out of approximately four hundred thousand Jews, some three hundred thousand were already deported from the ghetto. So within the outside walls, practically there were some four units. The most important was the so-called central ghetto. They were separated by some areas inhabited by

Aryans and already some areas not inhabited by anybody. There was a building. This building was constructed in such a way that the wall which separated the ghetto from the outside world was a part of the back of the building, so the front was facing the Aryan area. There was a tunnel. We went through this tunnel without any kind of difficulty. What struck me was that now he was a completely different man—the Bund leader, the Polish nobleman. I go with him. He is broken down, like a Jew from the ghetto, as if he had lived there all the time. Apparently, this was his nature. This was his world. So we walked the streets. He was on my left. We didn't talk very much. He led me. [Compare Steven Schwab's description of his interaction with the dog Kato.] Well, so what? So now comes the description of it, yes? Well . . . naked bodies on the street. I ask him: "Why are they here?"

The corpses, you mean?

Corpses. He says: "Well, they have a problem. If a Jew dies and the family wants a burial, they have to pay tax on it. So they just throw them in the street."

Because they cannot pay the tax?

Yes. They cannot afford it. So then he says: "Every rag counts. So they take their clothing. And then once the body, the corpse, is on the street, the Judenrat [i.e., the Jewish Council] has to take care of it."

Women with their babies, publicly feeding their babies, but they have no . . . no breast, just flat. Babies with crazed eyes, looking . . .

[The phrases "If a Jew dies and the family wants a burial" and "Every rag counts—so they take their clothing" seem related to both the dream's manifest content (the blue shirt with the buttoned-down collar) and the key event from my past.

"On the evening of July 1, 1976 my mother gathers a suit, necktie and shirt for my father's burial. She wants to bury him in a white shirt. My mother asks me if I will give her a white shirt that I own, which I do. I had worn the shirt on only one previous occasion. Thus, my father was laid to rest attired in my white shirt."]

Next day we went again [to the ghetto]. The same house, the same way. So then again I was more conditioned, so I felt other things. Stench, stench, dirt, stench—everywhere, suffocating. Dirty streets, nervousness, tension. Bedlam. This was Platz Muranowski. In a corner of it some children were playing something with some rags—throwing the rags to one another. He says: "They are playing, you see. Life goes on. Life goes on." So then I said: "they are simulating play. They don't play."

It was a special place for playing?

In the corner of Platz Muranowski—no, no, no, open. So I say: "They are . . ."

There are trees?

There were a few trees, rickety. So then we just walked the streets; we didn't talk to anybody. We walked probably one hour. Sometimes he would tell me: "Look at this Jew"—a Jew standing, without moving. I said: "Is he dead?" He says: "No, no, no, he is alive. Mr. Vitold, remember—he's dying, he's dying. Look at him. Tell them over there. You saw it. Don't forget." We walk again. Its macabre. Only from time to time he would whisper: "Remember this, remember this." Or he would tell me: "Look at her." Very many cases. I would say: "What are they doing here?" His answer: "They are dying, that's all. They are dying." And always: "But remember, remember."

We spent more time, perhaps one hour. We left the ghetto. Frankly, I couldn't take it anymore. "Get me out of it." And then I never saw him again. I was sick. Even now I don't go back in my memory. I couldn't tell any more.

But I reported what I saw. It was not a world. It was not a part of humanity. I was not part of it. I did not belong there. I never saw such things, I never . . . nobody wrote about this kind of reality. I never saw any theater, I never saw any movie . . . this was not the world. I was told that these were human beings—they didn't look like human beings. Then we left. He embraced me then. "Good luck, good luck." I never saw him again.

[It is noteworthy that Karski's statement "I never saw him again" is virtually identical to Steven Schwab's concluding statement (in the O.J. Simpson-Schwab text):

[Prosecutor]: And did you ever see the dog again after that?

[Witness]: I have not seen the dog again since then. That was the last that I saw of the dog.]

Therapy Session: October 10, 2018

. . . Session Five happened to be a particularly rich hour — a kind of microcosm of the whole analysis, like the overture of an opera in which all the themes are announced.

—Janet Malcolm, *Psychoanalysis: The Impossible Profession*.

I shall surely leave the world with my great longing to have seen and known a man I truly venerate, who has given me something, unsatisfied. In my childhood years I used to dream I had been with Shakespeare, had conversed with him; that was my longing finding expression.

—Cosima Wagner's Diaries (Friday, May 26, 1871).

I will make a Star-chamber matter of it.

—Shakespeare, *The Merry Wives of Windsor*. Act I, Scene I: Before PAGE's house.

OPENING COMMENTS

PATIENT: I want to tell you something. Something interesting happened this last week. I had sent my letters that I wrote to you to the chairman of the psychology department at the University of California at Berkeley and she responded to me. You know, Berkeley, that's a big-time school! I got the impression that she read the letters. She sent me an email. First, she thanked me for contacting her. Then she said I should keep on writing. Then she said that I was helping countless other people with my writings. Isn't that something?

[The email from Dr. Ann Kring reads:

Dear Gary:

Thanks for your note. It sounds as if you have been on quite a journey. I would encourage you to keep writing as your insights will be help to countless others.

Best wishes,

Ann Kring]

THERAPIST: So how did you feel about getting that email?

PATIENT: It was a big boost for me. I liked the fact that she said I would be helping countless people. I got a charge out of the fact that perhaps my writings would resonate with other people. That's important, the idea that what is going on inside yourself is resonating with other people also. It's not just inside yourself—it's in other people as well. It's like when you go to the movies. I mean you could just as well sit at home and watch a movie alone at home, but when you're at the *movie theater*, you get the idea of shared feelings. You see something funny and then you hear other people laugh as well. Or you see something sad; you're affected by that, but you see that other people are being affected by the same things that affect you. I guess therapy is like that too, ideally. You need someone out there who shares your feelings, who shares your inner world. It reminds me of something I read. It's by the playwright Arthur Miller. Did you ever hear of him? He wrote *Death of a Salesman*. He said that when he first started writing he got a boost out of the idea that what *moved him also moved other people*.

[In fact, I reproduce the Arthur Miller quote in the following passage from my autobiographical book *Significant Moments* (“some kind of *public business* was happening inside me, that what perplexed or moved me must

move others"). The following brief text arises in the context of a lengthier passage in my book whose themes include Freud's father's death, Freud's writing of his book *The Interpretation of Dreams* — and includes quotes by playwrights Arthur Miller and Henrik Ibsen (as well as a reference to Shakespeare). Ibsen, Miller, and Freud were notably autonomous, independent-minded men. The term "compact majority" (see text, below) was coined, incidentally, by Ibsen in his play *An Enemy of the People*, and was a favorite phrase of Freud's, quoted by Freud in his *Autobiographical Study*. What is significant here is that underlying my comments to the therapist later in this session about my twinship needs (my subjective need for mirror-image objects who resemble me) was my corresponding sense that I identify with and perceive a need to affiliate with independent-minded people who follow their own path in life, people like the historical figures Ibsen, Arthur Miller, or Freud. Ibsen and Freud did not bow to the compact majority (or the masses or "the group"), but, rather, uncommonly forged a lone path that, at times, led to their censure by the social order. When Miller was questioned by the House of Representatives' Committee on Un-American Activities in 1956 he refused, on the moral grounds of conscience, to identify others who might have had Communist ties who were present at meetings he had attended and was convicted of contempt of Congress.

Excerpt from *Significant Moments*:

As far as I personally am concerned, I am always conscious of continually advancing ["on my journey"] . . .

Henrik Ibsen, *Letter to Georg Brandes*.

. . . rightly proud of not having followed "the compact majority"

. . .

Yosef Hayim Yerushalmi, *Freud's Moses: Judaism Terminable and Interminable*.

The points I had reached [“on my journey”] when I wrote my various books now have a fairly compact crowd standing there. But I am no longer there myself; I am somewhere else, further on, I hope.

Henrik Ibsen, *Letter to Georg Brandes*.

From the beginning, writing meant freedom, a spreading of wings, and once I got the first inkling that others were reached by what I wrote, an assumption arose that some kind of public business was happening inside me, that what perplexed or moved me must move others. It was a sort of blessing I invented for myself.

Arthur Miller, *Timebends*.

His song was one that the father would surely not have recognized and would perhaps have found discordant. Yet somehow, in the balance, I feel he would not have been displeased, . . .

Yosef Hayim Yerushalmi, *Freud's Moses: Judaism Terminable and Interminable*.

. . . for, unlike . . .

Henry David Thoreau, *Walden*.

. . . his father who picked up his cap and walked on [“on his journey”], Freud does become, in the triumph of his intellectual achievement, the Hannibal of his fantasy.

J. Moussaieff Masson and T. C. Masson, *Buried Memories on the Acropolis: Freud's Response to Mysticism and Anti-Semitism*.

Freud's resolution of the guilt he felt . . .

Yosef Hayim Yerushalmi, *Freud's Moses: Judaism Terminable and Interminable*.

. . . following the death of his father . . .

Leonard Shengold, *Soul Murder: The Effects of Childhood Abuse and Deprivation*.

. . . was a psychological victory.

Yosef Hayim Yerushalmi, *Freud's Moses: Judaism Terminable and Interminable*.

Perhaps the truth is that he is at last himself, no longer afflicted by

mourning and melancholia. . . . Certainly he is no longer haunted by his father's ghost.

Harold Bloom, William Shakespeare's *Hamlet*.

My opening comments at this session foreshadowed, like the overture of an opera, three themes that would be elaborated in the ensuing 50-minute session: themes relating to autonomy, selfobject needs, and transitional phenomena (that is, the in-between space where the inner world and the “public business” intersect.)

INTRODUCTION

In the previous session I compared Kohut's concept of the mirroring/twinship selfobject with Winnicott's concept of transitional phenomena, or the transitional object:

I note that there is an underlying correspondence between Kohut's concept of selfobject needs – that is, an individual's need for alter-ego experience (twinship), idealization and mirroring—and Winnicott's concept of transitional objects, that is, “intermediate objects” that contain features of both self and non-self or, in the language of metaphor, a “translator” or “interpreter” who permits communication between two persons who speak different languages. Tamir, Y. “Adolescence, Facilitating Environment and Selfobject Presence: Linking Winnicott and Kohut's Self Psychology.”

In the twin fantasy the individual endows his daydream twin with all the qualities and talents that he misses in himself and desires for himself. Burlingham, D.T. “The Fantasy of Having a Twin.” All twin fantasies subserve multiple functions including gratification and defense against the dangers of intense object need. The twinlike representation of the object provides the illusion of influence or control over the object by the pretense of being able to impersonate or transform oneself into the object and the object into the self. Intense object need

persists together with a partial narcissistic defense against full acknowledgment of the object by representing the sought-after object as combining aspects of self and other. Coen, S. and Bradlow, P.A., “Twin Transference as a Compromise Formation.” The identical alter ego or twin is a derivative of the infant's mirror stage which states the necessity of identifying with an external image in order to develop an ego; I must identify as “I” that which is not me. Faurholt, G. “Self as Other: The Doppelgänger.”

While the transitional object, such as a teddy bear, is endowed by the child with the qualities he lacks and takes on the characteristics of his idealized object relationship; the child in a sense becomes identified and nurtured with the characteristics of his own idealized object relationship. The transitional object helps the child feel a sense of cohesion in the self, as well as a temporal coherence from the past to the present. Roig, E. “The Use of Transitional Objects in Emotionally Disturbed Adolescent Inpatients.” Winnicott proposed a developmental trajectory stemming from the infant's initial use of such a transitional object, dually vested as both an element of the external world and an illusory creation of imaginative inner life. Throughout life, this trajectory extends to other transitional phenomena such as imaginative play, meaningful expression of self through work, and all creative aspects of adult life. At their origin, these transitional phenomena involved “the use of objects that are not part of the infant's body yet are not fully recognized as belonging to external reality.” According to this theory, these intermediate areas of experiencing offer “a resting place for the individual engaged in the perpetual task of keeping inner and outer reality separate yet inter-related.” Harrison, R.L. “Scaling the Ivory Tower: Engaging Emergent Identity as Researcher.”

These issues of selfobject needs and transitional phenomena form the core of this session.

TWINSHIP/MIRRORING SELFOBJECT NEEDS—FEAR OF MATERNAL ENGULFMENT—AUTONOMY

At one point in the session, I discussed my sense of twinship with certain people, like my friend Craig and Dr. P—. I said I liked these people because I sensed that they were similar to me in certain psychological ways. Hence my sense of mirroring, as I saw it, was based on objective fact: because these people in fact resembled me, I saw them as mirror images, and then, because of my narcissism, I got an emotional charge out of these people.

My therapist seemed to think otherwise. She seemed to suggest that I was projecting an idealized image onto these people and that I ended up seeing my own projected image in them, and not their real selves. The questions she posed suggested that she thought that perhaps people like Craig and Dr. P— were not *objectively* similar to me. The sense of selfsameness I had with these people was based on a projection, in much the same way the child sees his teddy bear, a transitional object, as similar to himself. The child's sense of identity with the teddy bear is based on the child's projection of himself onto the teddy bear. The child and the teddy bear are not objectively similar.

I wonder about that. How would one distinguish between the following two people: One person feels mirrored by another person because he has projected an idealized image of himself onto the other person. Another person feels mirrored by someone because that other person is objectively similar. How would one compare and contrast these two different types of people?

Be that as it may.

My thoughts turned to group theory. In groups, a collection of people come together and, through an unconscious process, they engage in "homogenization." According to theory, people who adopt a group

identity will begin to think alike in important ways and begin to pool their feelings and fantasy systems. A group member's subjective sense that a fellow group member is similar to him is not based simply on projection. Group members begin to assume a shared group identity; in important ways they objectively begin to resemble each other. A group member's sense of twinship with other group members is based in part on objective fact, not projection. Group members are, in fact, similar because they have homogenized; in the language of group theory, these individuals have "de-differentiated;" they have lost aspects of their distinctiveness by assuming a group identity of shared feelings and fantasies. We find the starker example of this phenomenon in cults; cult members experience pathological homogenization, or loss of individual identity, and a corresponding intense bonding with each other.

It's interesting that some people, those with a high level of autonomy, might have a problem in groups. Kernberg points out that those persons whose thinking, individuality and rationality set them apart from other group members will be subject to attack or scapegoating by regressed group members who have assumed a group identity. The independent-minded person will not subsume his personal identity in a group identity, partaking in shared group fantasies; the independent-minded person will be experienced by regressed group members as a threat to group cohesion. I am such a person. I have a high level of autonomy — probably, pathologically so. And my thinking, rationality and individuality will tend to set me apart from regressed group members. I tend to have difficult interpersonal relations in regressed groups and, even one-on-one, I often have problems with individuals who tend to be group-oriented outside our dyadic relationship with each other: namely, people who are more concerned about the risk of alienation from others than they are about loss of identity, or losing their distinctive selfhood in groups. I tend to be attracted to independent-minded people. Perhaps one such

person from my past was Jay D. Amsterdam, M.D. I interacted with Dr. Amsterdam in 1978, when I was 24 years old. He was a 30-year-old psychiatry resident at the University of Pennsylvania School of Medicine who was conducting a drug study that I participated in. He struck me as independent-minded immediately at our first meeting. When I told him about my difficulties with my then-treating psychiatrist, I. J. Oberman, D.O. he said, “*That guy sounds like a prick – I’d advise you to stop seeing him.*” Many psychiatrists would have stood up for their fellow doctor out of professional loyalty. Then, years later, I discovered that in the year 2012, Amsterdam undertook the bold move of filing a 24-page ethics complaint against the chairman of Penn’s psychiatry department, where Amsterdam still worked. (*Amsterdam’s complaint opened with the following quote: “The challenge of pursuing science in a morally justified way is one that every generation must take up.”*). Amsterdam was the type of person with whom I felt a sense of twinship. And that sense of twinship, I believe, was based on the objective fact that he was independent-minded with a keen sense of moral values. He had a firm sense of right and wrong, and he appeared to act on that sense, perhaps at risk to himself.

Group-minded people tend to flock together based on a shared trait: they fear alienation from others, or censure by peers, more than they fear loss of their identity. Independent-minded people, on the other hand, fear loss of self or loss of identity more than they fear social alienation. Earlier in this book I discussed Bion’s belief that human beings are group animals who are constantly at war with our groupishness (because of our simultaneous need for autonomy). Bion hypothesized that each of us has a predisposition to be either more afraid of what he called “*engulfment*” (*fear of loss of personal identity*) in a group or “*extrusion*” (fear of a lack of connectedness, or alienation) from a group. This intrinsic facet of each of us joins with the circumstances in any particular setting to move us to behave in ways that act upon this dilemma. For example, those of us who fear *engulfment* more intensely (people like me) may vie for highly

differentiated roles in the group such as leader or gatekeeper or scout or scapegoat. Those of us who fear extrusion (or alienation) more intensely may opt for less visible roles such as participant, voter, “ordinary citizen”, etc.

Let us return to this idea: *One person feels mirrored by another person because he has projected himself onto the other person. Another person feels mirrored by someone because that other person is objectively similar. How would you compare and contrast these two different types of people.*

Can we offer tentative thoughts about the type of person who needs mirroring objects who are objectively similar to himself? I will venture the following idea. I believe that there is a cluster of personality traits in me that are all fragments of a single whole. These traits are as follows:

2. I have a **fear of engulfment** (or loss of identity) that outweighs my fear of alienation, or lack of connection from others.
2. I have a **low fear of alienation**. I am highly **independent in my thinking and behavior**.
3. I will be at risk of attack or **scapegoating** in groups and perhaps I also have leadership potential.
4. Perhaps I have a **highly-developed sense of values** and am willing to risk alienation from others to uphold those values. I do not have a “go along, get along” social style.
5. I have a high level of narcissism that places a premium on self-assertion as opposed to group cooperation.

6. The group-oriented person will lose his identity in groups, assume a group identity and share a sense of selfsameness based on the adoption of a shared group identity. And where does this lead the pathologically independent-minded person? He will, it seems to me, need to derive a sense of **twinship with other independent-minded people** who fear *engulfment* or loss of identity more than he will fear alienation from the group.

7. I am **intuitive**. I am a person who is able to intuitively sense another person's independent-minded personality based on little apparent evidence. Indeed, research findings show a link between a high level of narcissism and intuition. Kaufman, S.B. "Are Narcissists Better at Reading Minds? The Dark Side of Theory of Mind."

Kaufman's ideas might support the idea that an independent-minded narcissist will be able to pick out other independent-minded narcissists in short order. If that is so, maybe I can quickly identify whether certain others, such as Craig or Dr. P-, are objectively similar to me. A case can be made that my twinship/mirroring needs are related to an ability to objectively identify "twins" in my environment; my sense of selfsameness with certain others is not based simply on my projection of an idealized image onto these persons.

What I am saying by implication is that my twinship needs (which sound so extravagant) are comparable to the "twinship needs" found among members of regressed groups, where "twinship" involves affiliation with other homogenized people, that is, people who have "de-differentiated" and have objectively assumed like feelings and fantasies. Regressed group members are indeed alike because they have homogenized. I don't homogenize, that is, I don't assume a group identity — I find twinship with other independent-minded people. Independent-minded people, in

my opinion, are my twins who satisfy my selfobject needs. What I am saying is that both regressed group members and individualists seek their own kind of “twinship.”

I will add a striking psychoanalytic point. Psychoanalytic group theorists like Kernberg maintain that homogenization in groups has the effect of toning down envy. The individualist arouses envy in groups; he has something that is not shared with group members. Homogenized group members are psychologically equal; nobody has anything that anybody lacks. I am intrigued, in this context, with the fact that idealization can be a defense against envy in one-to-one relationships. See Kanwal, G.S., 'Benevolent Transformation' and the Centrality of Idealization Dynamics in Indian Culture." My idealization of other independent-minded people (people like Craig and Dr. P-) tones down my envy of them. We might say that my idealization of independent-minded persons who serve my mirroring/twinship needs tones down my envy similar to the way homogenization tones down envy among group-oriented people. That is, perhaps there is a symmetry of psychological functioning between the twinship behavior of independent-minded persons (who fear engulfment and loss of identity) and regressed group members (who fear a lack of connection from others).]

PATIENT: What I think is that Craig and I were similar. I think there was something going on between us. I don't think I was just imagining that Craig and I were similar. Can I tell you some anecdotes?

THERAPIST: Do you think I would say no?

PATIENT: OK. So this is really strange. At one point when we were working together I pointed out to Craig that his name C– D– was an anagram of the phrase “gray dice.” You know dice, like in craps. So some

time later, Craig went out and purchased this cologne called Gray Flannel. I remember that was in mid-September 1987. And he used to douse himself with this cologne all the time. It was really noticeable in the office. Then there was something else. I had a shirt. It was gray with orange pinstripes. I still remember, it was a Christian Dior shirt. I used to wear it to work. What Craig did was — he went out and bought an identical shirt [in mid-September 1987]. I mean, it was exactly the same Christian Dior shirt — gray with orange pinstripes. The Gray Flannel cologne and the gray shirt that was identical to mine — it was a reference to my observation that I pointed out that his name was an anagram of “gray dice.” I don’t think this is all just coincidence. Oh, then, there is something else. Recently, just a few years ago, I was searching Craig on the Internet and I found out that his mother died. I read the obituary on the Internet. And it mentioned something that I never knew before. Craig never told me about this. He had a brother named Gary. He never told me that. So I think that’s all interesting. As I say, my thoughts and feelings about Craig were not just my imagination — there was something going on between us.

THERAPIST: How do you explain the fact that he seemed reluctant to be your friend.

PATIENT: I think we were in fact similar and in fact he liked me. But I think his defenses got in the way. That’s what I think. It’s not that he didn’t like me, but his resistance to me was based on his defenses and not on the fact that he didn’t like me or that I was simply imagining things about him. Oh, and here’s something else. Craig and I worked with a woman, and one time she said something to me (late August 1987). (Note that this was weeks before Craig purchased the Gray Flannel cologne and the gray shirt identical to mine in mid-September 1987.) She said: “You and Craig have so much in common. You should make an attempt to be

friendly with him. You could become friends with him. Why, the two of you could end up being friends for life!" So that was another person saying this. She thought we had a lot in common.

THERAPIST: So you felt gratified that she validated your feelings.

PATIENT: Yeah. And I'm thinking, if this could be going on between me and Craig, maybe I wasn't just imagining the fact that Dr. P—and I were similar or that he liked me. That's what I'm thinking. I think it's possible.

TRANSITIONAL PHENOMENA – MATERNAL ENGULFMENT

[At another point in the session, I talked about my feelings of engulfment by my mother.]

PATIENT: I felt that my mother tried to impose her agenda onto me.

THERAPIST: Can you talk about that? Can you talk about how she tried to impose her agenda onto you?

PATIENT: It's hard for me to identify how she tried to do it. I mean it was psychological. It was her style of interacting with me. But I think of a particular thing. It sounds kind of trivial, but it's a kind of metaphor for how my mother interacted with me. This went on throughout my life. When I was a kid my mother always picked out clothes for me that she thought I should wear. She would always pick out things that she liked. She wasn't interested in what kind of clothes *I* liked. She seemed to kind of force her taste in clothes on me. That's kind of trivial, but I see that as a metaphor for how she would impose her agenda onto me. I think that was riddled throughout our relationship.

THERAPIST: Well, you know when a child is small, the mother often chooses clothes for a child. [The therapist seemed to imply that my mother's behavior was simply typical, that my mother was simply exercising a maternal prerogative.]

PATIENT: Well, this went on when I was older too. I remember a specific incident. It was in late June of 1968 when I was 14 years old.

[I experienced the therapist's comment as an invalidation; I interpreted the therapist as saying, "Your mother was acting rationally and appropriately, and your aversive feelings were inappropriate." I then felt prompted to attempt to "prove" the truth of my assertion about my mother's engulfing behavior by reporting additional "evidence," rather than exploring the psychological meaning for me of my feeling that my mother was engulfing. In my opinion this is an instance in which the therapist failed to provide a "facilitating environment" for the exposition of my inner world. The therapist should have responded with an exploratory question or comment that encouraged me to talk about my feelings of engulfment rather than offering a comment that amounted to a rationalization of my mother's behavior.]

PATIENT (continuing): We were going to Atlantic City in early July. And I went clothes shopping with my mother and I picked out a bathing suit I liked. And my mother didn't like the bathing suit I picked out. She wanted me to pick out a different bathing suit [one that suited *her* tastes.] So 14 is already pretty old. I think that says something about my mother. [I see deep psychological meaning in my mother's behavior, namely, her insistent need to choose clothes styles that suited *her* tastes rather than mine. Indeed, I view my mother's behavior as relating to my mother's own transitional phenomena. In childhood, my mother had a passionate interest in dolls. I suspect this was a transitional phenomenon; my mother's interest in playing with dolls seemed to resemble a child's

relationship with a transitional object, such as a teddy bear or other object. My mother reported that she would spend hours making clothes for her dolls. It is telling that my mother developed sophisticated, professional seamstress skills. As a young adult she got a job in a lampshade factory sewing lampshades, based on skills she acquired on her own as a child sewing clothes for her dolls. My mother had a sewing machine of her own as an adult and made many of my sister's dresses. My mother also knitted and made sweaters for my sister and me. These adult skills are evidence of the intensity of her investment in her childhood activity of making clothes for her dolls. Is it possible that my mother's actions in picking out clothes for me that matched *her* tastes – which I viewed as aversive – was evidence that at an unconscious level my mother viewed me as a transitional object: is it possible that she viewed me as one of her dolls from childhood?

(I note tangentially that the playwright Henrik Ibsen as an eight-year-old boy had a keen interest in a toy theater—he called it a “gymnasium of the imagination”—for which he created imaginary dialogue for dolls. One of his most famous plays, *A Doll’s House* –about a mother who leaves her husband and children – was excoriated by contemporary critics as an affront to public morals. Ibsen’s creative productions (which can be viewed as transitional phenomena) – namely his writings – led to his public censure somewhat in the way my own writings – that is, my posting imaginary dialogue between Dr. P— and me on Twitter – led to my being hauled into court. Oddly, there is a point of comparison between the theme of *poisoning* in several Ibsen plays and my childhood experience of contracting scarlet fever at age three from spoiled milk my mother allowed me to drink, a biographical fact I elaborate in the Appendix to this letter. In Ibsen’s play, *Ghosts* a mother provides *poison* to her son to enable the son’s suicide in expiation of his father’s sins; *An Enemy of the People* pits a truth-fanatic (who discovers that the waters of a spa town are *polluted*)

against the town's mayor and its citizens (*compare the action of Dr. Amsterdam challenging the professional conduct of his department chairman*); and in *The Master Builder* a mother, out of a perverse sense of duty, kills her twins – she contracted a fever because she could not stand the cold, but, despite the fever, she insisted on breast-feeding the twins, who died from her *poisoned milk.*)

[What are the psychoanalytical implications of my mother treating me like a transitional object in terms of both her relationship with me and the effects of that kind of parenting on my psychological development? What are the psychological implications of a mother treating a child as a transitional object? Research findings indicate that it appears that mothers who used their children as transitional objects led, in turn, to the children's emotional development becoming fixated in the in-between transition space. Giovacchini, P.L., "The Psychoanalytic Paradox: The Self as a Transitional Object." Am I one of those individuals whose emotional development has become fixated in the in-between space? What would that mean, precisely?]

Thoughts about My Relationship with My Mother

I experienced my mother as overprotective and unable to allow me to become a separate person, with the result that I felt ineffective.

I perceived my mother as imposing her wishes on me, dominating and controlling me to attain submission and perfection, forcing me into passive submission and creating a sense of fusion. I felt surrounded by my mother's "all-consuming, insatiable demand" to be absolutely needed.

I have often thought that there was an interplay of food and love and nurturance, demand and desire, in my early relationship with my mother

that contributed to my ascetic trend as a coping mechanism. Through my asceticism I was able to establish a distorted sense of autonomy and effectiveness.

I think I had both a wish for and a fear of fusion with my mother and I was engaged in a psychological struggle to separate my identity from my mother's identity. It's as if I was thinking: "I don't need you. I don't need anything. I don't need human connections to survive. I am totally independent."

Perhaps this was a displacement of unexpressed anger at my mother. I felt rage at my mother. Did I have repressed oral sadomasochistic conflicts with my mother? In being so hard on myself was I trying to control and punish my introjected mother? In some sense perhaps I was engaged in a manic defense through which I struggled to control the internal representation of my mother, to the point of determining who lives and who dies. The violence that I commit on myself through my asceticism is possibly "a reflection of the violence that is felt to be done to the internal parents and their relationship."

I experienced my father as minimally involved, inadequately responsive to me, and unable to foster my autonomy by providing a benevolent disruption of my symbiosis with my mother. He was unable to facilitate my sense of being special and lovable. What I am describing is a disrupted relationship with my mother and a distant uninvolved relationship with my father. I sense that my internalized image of my father is split and unintegrated. I suspect I have one internalized image of my father based on his third-party status vis-a-vis my dyadic relationship with my mother; a second internalized image of him grows out of my individual interaction with him. The former image is a debased one owing to both my mother's persistent devaluation of my father as well my own oedipal conflicts. While the latter image is idealized and gratifying. I am guessing these conflicting internalized paternal images exist side by side.

My mother was intrusive, over-involved, and lacking sensitivity to my needs and abilities. I had the sense that my mother could not intuitively

grasp my needs, particularly my emotional needs, because she reacted to them according to her own desires, giving little room for the my own individual expression.

I suppose I had a sense of loyalty and adherence to my parents' covert demands, so that I disavowed a desire to be independent and, thus, I was unprepared for adolescence. As I say I perceived my father as unreliable and intermittently available. In some ways I was pressured to grow up quickly, control my needs, and preserve my parents' marriage, all of which created difficulty with separation-individuation.

I had an impaired sense of self. I had a paralyzing sense of ineffectiveness and helplessness—a sense of self that underlay my difficulties with separation and autonomy.

There was a lot of discord in my family; my parents argued all the time. I struggled with parental demands, as well as negative emotions and a poor self-concept. Perfectionism was always a big thing with me.

At times there was low parental care, yet, paradoxically, a lot of maternal control. I perceived a lack of emotional involvement with and trust in my parents and a lot of self-blame and guilt for family problems.

I think I am significantly more self-reflective than other people, less concrete, and more internally focused, with a more contradictory and evaluative style that contains harsh judgments of myself.

I struggle with intense and harsh self-scrutiny that is accompanied by a lot of depressive feelings. I sometimes think that I am engaged in a desperate and distorted struggle to feel adequate, worthy, and effective, but in a way that leaves me feeling even more inadequate, unworthy, and ineffective.

APPENDIX: LAST THERAPY SESSION WITH PREVIOUS THERAPIST

On March 12, 2018 I had a final session with my previous therapist. The following is a summary of my thoughts about that session, written a brief time later. The timing of the session was significant. I mentioned in a previous letter that my former primary care doctor, Dr. P–, had taken out a protection order against me in the year 2016, alleging that I had been engaged in Internet stalking of him. Dr. P– and I appeared in Superior Court together on July 28, 2016 at which time I consented to a protection order without admissions. I also reported in that letter that I later formed the belief that Dr. P–'s affidavit to the court had been perjured – that my *court summons* was bogus – and that I thereafter filed a criminal complaint against him with the FBI; I filed that criminal complaint on March 13, 2018, one day after my last session with my previous psychotherapist.

Dr. P– was very much on my mind at the therapy session on March 12, 2018 and thoughts about him colored my clinical narrative, though I did not mention him or even allude to him. Perhaps, my reference in the following text to the fanciful image of Shakespeare sitting alone in a prison cell is a symbolic transformation of my thoughts about having been *summoned* to court, or “called to account,” by Dr. P–. Then, also, at this moment, I think of Shakespeare’s Sonnet no. 30, which I reproduce in modern English translation below. The opening lines of the sonnet remind us of being called to court (*cf.* “court sessions” and “summon a witness”). This is followed by a slew of money-related terms, including “expense,” “grievances,” “account,” “paid,” and “losses.” The phrase “tell o’er” in line 10 is an accounting expression (*cf.* the modern bank teller) and conjures up an image of the narrator reconciling a balance sheet of his former woes and likening them to debts that he can never pay off in full. At the end of the Sonnet the narrator’s recollection of an anonymous, absent friend soothes him in his woe:

When I summon the remembrance of past things to the court of sweet silent thought I regret not having achieved many of the things I strived for, and I add new tears to the old griefs, crying about the waste of my valuable time. It is then that I can drown my eyes, which don't often flow, thinking about precious friends who are dead; and weep all over again for love that has lost its pain long ago; and cry over many a sight I'll never see again. At those times I'm able to cry over sorrows I've long ago let go of, and sadly count them one by one, and feel them all over again, as though I hadn't suffered their pain before. But if, while doing that, I think about you, my dear friend, all those losses are restored and my pain ends.

It is hardly coincidental that my only misdeed, as alleged by Dr. P—, was that I had created imaginary humorous conversations between him and me and published them on Twitter, like Shakespeare writing dialogue for his plays—or the eight-year-old Henrik Ibsen writing dialogue for the dolls of his toy theater. Were my Tweets guided by my unconscious sense of Dr. P— and me as Shakespearean characters; perhaps I played the buffoonish Falstaff to Dr. P's young Prince Hal (*Henry V*). In Shakespeare's *Henry IV* the two men jest with one another and tease one another. Were my Tweets in fact a transitional phenomenon in which I created an in-between space that bridged my internal world of fantasy with the objective and real, namely, the person of Dr. P—. If we view my Tweets as a transitional object it raises an intriguing issue of psychoanalytical interest: was my escapade with Dr. P— part of a repetition compulsion in which I provoked the world of external objects to punish me for my use of my transitional object? As I mentioned earlier in this letter, I contracted scarlet fever as a three-year-old by drinking spoiled milk (*note the distinct noxious odor of spoiled milk and its relation to the smell of the early transitional object*) from my bottle (*was my bottle a transitional object?*); the Philadelphia Health Department got involved in the affair by quarantining our house. Was this event from age three an early instance of the State punishing me because of my use of a transitional object?

Was Dr. P-'s protection order related to my possible need to be punished by the State because of my use of a transitional object, namely, my writings about Dr. P- on Twitter? One might speculate.

In the March 12, 2018 session reproduced below I discussed my writings with my former therapist, and the fact that in my mind these writings conferred on me a kind of immortality. In that session I emphasized my strong need to transform my private, inner world into some kind of public business – perhaps a reference to Winnicott's transitional space, the in-between space where the inner world and the “public business” intersect. I alluded to the issue of autonomy (*see* the image of Shakespeare alone in prison) and the use of transitional phenomena (writing) to create the “I” by delineating the “me” from the “not me” (“By the act of giving the ‘I’ an independent existence, the self clarifies the ‘I’, defines the ‘I’, and establishes the uniqueness of the ‘I.’”). My implicit meaning at that March 2018 session was clear; for me, writing creates a transitional space where my “I” resonates with the world of external objects that exist beyond the self. *See* Di Cintio, M. “Ordered Anarchy’: Writing as Transitional Object in Moise and the World of Reason.”

LAST SESSION WITH PREVIOUS THERAPIST: MARCH 12, 2018

The following text has several points of comparison with the October 10, 2018 session with my present therapist:

PATIENT: So this is our last session. I was sitting outside experiencing a kind of emotional high. I felt like I was floating. You know I was feeling – and maybe you had this feeling as a kid – on the last day of class in elementary school. You feel nostalgia about the past year and a sense of loss. But there's also this excitement. This anticipation. You're anticipating the next school year in September and your new teacher.

You have a feeling as if you're floating; everything takes on an unreal quality.

I feel we did important work. Some of the most important work I've done. I thought my letters were very important for me. They helped me work out things in my mind. I revealed things through the letters. And now I've turned the letters into a book. And you inspired me to do that. I feel so strongly that we *are* what we create. That's what lives on after us. I think about the cavemen. They lived 40,000 years ago. And we would know nothing, absolutely nothing, about them today if they hadn't left us their cave paintings. And their tools, their flint tools. That's what's left and they have gained a kind of immortality — these people who lived 40,000 years ago. But they are immortal only because of what they created. Otherwise we wouldn't know anything about them.

I feel so strongly that we have to make our inner world public. Put it outside ourselves. Otherwise, when we die, nothing is left. I mean, you place so much emphasis on relationships. But relationships are not the road to immortality. I mean the cave men had relationships. They were social just like us. But we know nothing — absolutely nothing — about them based on their relationships. Their relationships mean nothing after they're gone. We remember them only because they took their inner world and put it outside themselves. It reminds me of what Freud told Joan Riviere. I think Freud trained her. She was English. She did English translations of Freud's writings. He said to her: "Put your inner world outside yourself. Put it down on paper. Give it a separate existence — outside yourself." I think about that quote a lot. It means so much to me. It just resonates with me. I mean, take Shakespeare. If Shakespeare had been sent to prison before he had written anything, say he committed a crime — so he was in prison and the jailors refused him any writing implements. He spends his life in prison and he never writes anything.

We would never know who Shakespeare was. When he died, that would be it. The end of Shakespeare. He would have been just another prisoner who spent his life in jail. It's through what he wrote that people remember him and who he was. I think about that. And yet, in his inner world he was still the very same Shakespeare, whether he wrote or didn't write.

[The following are my comments in the original summary written in March 2018:
What I seem to be saying is that by giving the "I" an independent existence outside the self, the "I" not only preserves itself but something else. By the act of giving the "I" an independent existence, the self clarifies the "I", defines the "I", and establishes the uniqueness of the "I". Without our creations we remain simply indistinguishable *human animals* – members of a herd. Our creations, that is, our memorialized symbolization, actually create the "I" in an important way; through these creations we stand outside the herd and establish our *humanity*. These are the introjective concerns of identity and self-definition. A person's creative products, therefore, both immortalize and actually modify and even create the "I." The "I" is actually redefined and changed by those parts of itself that are given an independent existence.]

THERAPIST: It sounds like you want me to remember you.

PATIENT: Well, I want to be remembered.

THERAPIST: Did you really value our relationship?

PATIENT: Yes. You know it reminds me of when I was a kid. We used to go to Atlantic City every summer in early July. My father had friends in Atlantic City and we stayed with them for two weeks each year. I loved that so much. That was the high point of the year for me — two weeks in

Atlantic City. And to get from Philadelphia to Atlantic City you have to cross the Delaware River. So you have to go over the bridge. You were a bridge for me. You helped me get across the river. And something even more powerful for me. When I was very young we used to take a different route. We didn't cross the bridge. [We took the ferry.] There was a ferry boat that crossed the river and we crossed over on the ferry. I loved that in the late afternoon, in the late afternoon sun. [Note added at this writing in October 2018: The transitional object or in-between space is a bridge that links the subject's inner world of fantasy with the world of sensory impingement. Note that the word "ferry" can be seen as a play on the word "furry," as in a "furry teddy bear." Both a *ferry* and a child's *furry* teddy bear represent an in-between space.]

PATIENT: The excitement was so powerful that I would start to feel sick. I remember when I was little I said to my parents, "I'm so excited that I feel sick." And they said, "Well, if you're feeling sick, maybe we should turn back." I shut my mouth! And the ferry was so powerful an experience for me. You were like the ferry boat. You helped me get across the river.

THERAPIST: That's a powerful symbol. . . . Usually at the last session, I talk about my feelings about the client.

PATIENT: Oh, I would prefer that you not do that. It would make me uncomfortable. I don't want to know what you think. I want to preserve the mystery. I don't want to be burdened by your feelings. I don't want to remember that and maybe be haunted by what you say. I want you to remain a blank screen. The blank screen is a safe place. I have powerful feelings of curiosity. Intense curiosity that's almost painful for me at times. And I think I get off on having these feelings. I want to remain curious about you and your thoughts. It's emotionally gratifying for me to be curious about people. I think the state of being curious is more

important to me than actually knowing what I want to know. You know, we were talking about Shakespeare. It reminds me of curtain calls at the theater. At the end of the performance, the actors return to their actual identity and stand in front of the curtain for the applause. And I hate that. I don't want to lose the illusion that the characters were real. I want to just remember the characters — not the real actors. You know, talking about Shakespeare, it reminds me of *The Tempest*. That was Shakespeare's last play. He died after that. That famous speech that Prospero gives at the end of the play. "Our revels now are ended." That was Shakespeare's curtain call. But he put it in the voice of the actor, in the voice of the illusion. Talking about death it reminds me of President Kennedy's kids, Caroline and John. Do you remember John Kennedy? Well, he died in a plane crash in 1999. And his sister, Caroline read Prospero's speech at his funeral. I guess analytically, I guess I'm saying I'm really playing a role here. This is not my real self.

THERAPIST: What role do you think you're playing?

PATIENT: I don't know. It's just intuition based on my associations here. Well, I don't think I present my complete self here. For example, I'm a funny person.

[*Note added at this writing in October 2018:* When I say "I'm a funny person," am I unconsciously referencing the humorous imaginary conversations I wrote on Twitter between Dr. P— and me: the imaginary conversations that led Dr. P— to file for a protection order against me?]

THERAPIST: You've never said anything funny here.

PATIENT: Yeah, I'm a funny guy. Remember the TV show *Seinfeld*?

THERAPIST: Yes.

PATIENT: Well, at the end of each season of the show I would send Jerry a letter. It was a funny letter. I don't know if he ever read them. I read that he doesn't read fan mail. The letters were funny. As a matter of fact, my very last letter talked about Shakespeare and *Hamlet*. I talked about the characters on the show as if they were characters in *Hamlet*. I talked about Elaine as if she were Ophelia. So I guess I didn't reveal that aspect of myself. . . . But, you know, I think maybe you'll be reading about me in the newspaper in the future.

[Am I unconsciously alluding to a newspaper article Dr. P— had caused to be published about himself in a local newspaper in the year 2015? Does my reference to a fantasied newspaper article about me suggest my envious competition with Dr. P—?]

I want to get my book published and I want it to be a best seller. Maybe made into a movie. Someday you'll be in a *movie theater* watching the movie and you'll say to your friend, "The guy who wrote the book was once a client of mine."

[You will recall that my opening comments to my present therapist on October 10, 2018 referenced sitting in a movie theater: "It's like when you go to the movies. I mean you could just as well sit at home and watch a movie alone at home, but when you're at the *movie theater*, you get the idea of shared feelings. You see something funny and then you hear other people laugh as well. Or you see something sad; you're affected by that, but you see that other people are being affected by the same things that affect you." I rarely talk about movie theaters in therapy sessions; I haven't been to the movies in 26 years.]

THERAPIST: I could never do that because of client confidentiality. I need you to sign a release of information form so that I can talk to your next therapist.

THERAPIST: Good luck.

PATIENT: Thank you. Good bye.

The following dream from April 2019 ties together several threads in this letter:

The Dream of Eggs and Lox

Upon retiring on the evening of April 22, 2019 I had the following dream:

I am in Atlantic City on vacation with my father. It is a Friday morning. I am very hungry. My father and I go to a restaurant in the inlet. The waitress says: "It's the end of the week. We have no food. We are waiting for a food shipment. I can serve you, but only one meal. One of you will have to go to another restaurant." My father and I sit at a table. My father is served an order of eggs and lox. I am angry with my father. I think: "Any other father would let his son eat the one meal and make the sacrifice of going hungry. Because I have a selfish father, I will have to go hungry." I think, "I have to have my blood drawn later, so at least, I will not have had a high fatty breakfast." I leave the restaurant and my father and take a walk alone on the boardwalk. I come to Vermont Avenue. My family used to stay at Vermont & Oriental Avenues every summer with friends of my father. The Vermont Avenue Apartments, which I recalled from childhood, have been torn down and I have pangs of nostalgia. In their place have been built a large, modern apartment house. It is pleasing, but it just isn't the way I remembered Vermont Avenue. There are shops on the first floor. There are many tourists there. I said to one of the tourists, a woman: "The Vermont Avenue

Apartments used to be located here.” She said, “I didn’t know that. I never saw that building.” I said, “Did you see the movie Atlantic City? It starred Burt Lancaster. There was a shot of the Vermont Avenue Apartments in that movie.” She said, “I never saw that movie.” I walk on down Vermont Avenue, hoping to come to Oriental Avenue, to see the house where we used to stay. Everything has changed. All the buildings have been torn down. There are sand dunes everywhere with pine trees planted everywhere. I get lost.

EVENTS OF THE PREVIOUS DAY:

1. I mailed a copy of a book I had written, *The Dinner Party* to a former coworker, Jesse Raben. This was the first time in thirty years that I had any contact with Raben. That was odd. Was it related to the fact that the following day (April 23) was Shakespeare’s birthday? The book is a short story that reads like the script of a play; the book contains several brief quotes from Shakespeare. The young Dr. Sigmund Freud is one of the characters in the book; he is a guest at a dinner party.

Note the theme of the book – *The Dinner Party*. The book is about a fictional dinner party at the home of the composer, Richard Wagner and his wife, Cosima. The main course at the dinner is Newcastle Salmon, described as “pink and moist” (like a vagina): “The principal dish at [dinner] had been an entree of Newcastle salmon, *pink and moist*, and spinach Farfalle (emphasis added).” May I offer the thought that the following predicate thinking applies: salmon, “pink and moist,” vagina, lox, locks.

A fictionalized Raben is a central character; he is a young composer who pursues Richard Wagner to obtain the old master’s appraisal of his compositions. That is, Raben seeks the approval of an idealized father-figure; he attempts to attach himself to a man of importance. Might we

say, psychoanalytically, that Raben exhibits a “passive surrender to [an] idealized object[],” a striving that can be associated with ego ideal pathology? Blos, P. “The Genealogy of the Ego Ideal.”

I had envisioned the character Raben as an extremely intelligent and talented individual, who early made his brilliance evident. He had experienced substantial pressures to succeed and early had instilled in him expectations of success; he absorbed the impression that he was special and destined for greatness. He had a knack for drawing attention to himself and tried to attach himself as a “bright young man” to an older and experienced man of considerable stature who was attracted by his brilliance and flair.

2. I was scheduled to have a semi-annual check up with my primary care doctor, Richard J. Simons, M.D. the following day, on April 23, and probably had anxieties about the appointment. Dr. Simons serves as Senior Associate Dean for M.D. Programs at a major teaching hospital. I had sent Dr. Simons a copy of my book *Psychotherapy Reflections* the previous October, apparently trying to impress him with my brilliance.
3. At about 6:20 PM on the afternoon of April 22 I was standing in the mail room in my apartment building in front of the mail boxes. I was reading a piece of mail I had received – it was a letter from Penn State, my college alma mater, soliciting donations for the Penn State library. Someone walked into the mail room and said “excuse me” to me. I was blocking access to his mail box. His statement, “Excuse me” startled me. That person was none other than Dr. Martin A. Ceaser, M.D., a psychoanalyst whose professional office is located in my apartment building.
4. On April 21 I had posted the following jesting post on my Facebook

page, referring to my former primary care doctor, Dr. P–: “Why don’t you and your wife invite me over to your place sometime. I’d love to sample your wife’s delicious kreplach and her amazing liver knishes!!” Then, on April 22, I posted on my Facebook page another jesting post, again referring to Dr. P–: “FREEDMAN: Well? DR. P–: Forget about it. You’re not coming to my house. Find yourself a kosher deli.”

5. On April 22 I revised my book *Psychotherapy Reflections* to include the following statement about Shakespeare’s play, *Henry IV* (“The two men [Falstaff and Prince Hal] jest with one another and tease one another.”). I wrote:

*It is hardly coincidental that my only misdeed, as alleged by Dr. P–, was that I had created imaginary humorous conversations between him and me and published them on Twitter, like Shakespeare writing dialogue for his plays– . . . Were my Tweets guided by my unconscious sense of Dr. P– and me as Shakespearean characters; perhaps I was the buffoonish Falstaff and Dr. P– was the young Prince Hal [Henry V]. **The two men jest with one another and tease one another.** Were my Tweets in fact a transitional phenomenon in which I created an in-between space that bridged my internal world of fantasy with the objective and real, namely, the person of Dr. P–.*

6. April 23, the following day, was Shakespeare’s birthday.

ASSOCIATIONS:

1. Atlantic City. The happiest times of my childhood were spent in Atlantic City, New Jersey. When I was a child we spent two weeks in Atlantic City every year in the beginning of July at the home of friends of my father. My father and I continued to go to Atlantic City alone together when I was 11-14 years of age. My parents’ marriage was contentious; marital discord was common. My father often had a

depressed mood at home. But my father showed a different side of himself in Atlantic City – he was sociable, care-free, and clearly enjoyed the weeks we spent there. It was as if my father were a different person in Atlantic City. He became the father I wanted to have. I wonder whether my early salutary experiences with my father in Atlantic City were instrumental in facilitating a partial resolution of my Oedipal conflicts. It was in our annual trips to Atlantic City that I came to see my formerly fearsome “Oedipal father” as harmless or beneficial. This might have been quite a striking unconscious realization for me in early childhood.

2. There is a possible overdetermination of the theme of *vacation*:

a. The dream manifestly refers to Atlantic City.

b. While I worked with Raben, he took a ski vacation to the State of Vermont. I kept the postcard he sent to a workplace supervisor, Constance Brown. Raben wrote on the postcard: “All I do is sleep, ski and eat.”

c. On one occasion Constance Brown mentioned to me that she took a vacation to Lancaster, Pennsylvania to visit Amish country. (The dream reference to Burt Lancaster might symbolically refer to the city of Lancaster). (I note that Burt Lancaster also starred in the movie, *From Here to Eternity*, which contains a famous beach scene. See ¶9, below.)

3. I speculate that the weekly food shipments in the dream symbolize weekly psychotherapy sessions. In the year 1990 I was in weekly consult with Stanley R. Palombo, M.D., a psychoanalyst. I saw him on Friday afternoons, the day mentioned in the dream. Perhaps I equate the consumption of food with the acquisition of self-knowledge. The hunger expressed in the dream might symbolize a hunger for self-knowledge

gained through psychoanalysis.

4. Knishes and Kreplach. When we stayed in Atlantic City when I was a child, Ethel Blum, the widowed, immigrant matriarch of the family, used to cook an extravagant, traditional Jewish meal one night of our stay — *The Dinner Party*. I loved the knishes. My father said that Mrs. Blum, who opened a grocery store located in the ground floor of her house, had started her food career by cooking and selling knishes on the beach in Atlantic City. I suppose that was in the 1930s. One might say that Mrs. Blum was an Atlantic City version of Mrs. Stahl in Brighton Beach, New York. An article states: “The real Mrs. Stahl was a local lady who sold her home-baked knishes up and down the beach in the 1930s. In 1935 she was persuaded to open a store, which thrived through the 1980s.”

Ethel Blum's husband, who died in 1936, was named Henry.

Years ago I got into a discussion with my sister about the heart and the coronary arteries, part of which I memorialized:

Tuesday November 24, 1992

Telephone call to sister: Sister discusses her plans for Thanksgiving, explaining plans to go to friends' house for dinner. Says she saw on television a film of a coronary artery bypass procedure. My father had undergone such a procedure on June 30, 1976 (he died following the operation, on July 1, 1976). I mentioned that the name of the surgeon who performed the procedure was Dr. Michael Strong, and noted that Dr. Strong is now a professor of cardiothoracic surgery at Hahnemann. (Dr. Strong is a native of North Carolina.) (Note that the issues of loneliness at Thanksgiving and sclerotic heart disease can be related at a basic symbolic level, with the loneliness symbolizing oral frustration and sclerotic heart disease symbolizing myocardial "frustration," or ischemia. Prolonged oral

frustration leads to death by starvation just as prolonged ischemia leads to death by infarction.)

I mentioned to my sister in that 1992 telephone conversation that the coronary arteries supply blood to the heart muscle. My sister interjected: "But I thought arteries take blood away from the heart. Veins bring blood to the heart." I explained to my sister that the heart is a muscle, it is living tissue. As such the heart needs blood just like any other tissue in the body. I said that the coronary arteries are the heart muscle's private source of blood. Then I offered the following analogy: "Do you remember the Blum Delicatessen in Atlantic City? The store provided food to the people in the neighborhood. But do you remember the stairway in the Lischin kitchen that led directly down to the store? The Lischins used the food in the store ~ which they sold to customers ~ for themselves also, to feed themselves. So the store was doing two things. It supplied food to the neighborhood, but it also supplied food to the Lischins themselves. That private back stairway from the Lischin kitchen down to the store is analogous to the coronary arteries, which is the heart muscle's own private blood supply. The front door of the store, which allowed access of neighborhood customers to the store, is analogous to the arteries that carry blood away from the heart."

5. Eggs and Lox. This is an obvious reference to eggs and sausages, which I associate with Dr. P—. In my Twitter posts about Dr. P— I frequently jested about *a breakfast of “eggs and sausages.”* At my first consult with Dr. P— on September 29, 2015 he asked: “Did you ever have a heart attack?” I replied: “No. I never had heart disease of any kind.” He said: “I want to get a lipid profile. You’ll need to have your blood drawn.” I said: “But I had breakfast this morning.” Dr. P— responded: “That doesn’t matter as long as you didn’t have a high fatty breakfast, like eggs and sausages.”

But doesn’t the word “lox” suggest another possible meaning? Lox also

relates to “locks.” I suspect that the lox in the dream is a symbolic reference to Dr. Ceaser who wanted to “unlock” his mailbox. I frustrated Dr. Ceaser’s goal by standing in front of his mail box. Might there be something sexual here (mail box = the female genitalia)? Is there a relationship to my father frustrating me in the dream? In the dream I wanted to eat the eggs and lox but my father took the meal for himself. We might say that in the dream my father frustrated *me*; in the event of the previous day involving Dr. Ceaser, I had frustrated Dr. Ceaser.

In my therapy session on October 22, 2018, which I reproduce later in this book, I talked with my therapist about a “locked box” that I viewed as symbolic of my unconscious. My mind had created the following symbolism: *A man gaining access to a locked box is analogous to a psychoanalyst and his patient working together to unlock the contents of the patient’s unconscious (the “mail box”).* When I saw Dr. Ceaser (a psychoanalyst) in the mail room of my apartment building about to retrieve his mail from his locked mail box on the afternoon of April 22, it must have had an uncanny and startling effect on me; it was a reality representation of my pre-existing metaphor (locked box = the unconscious).

In the letter about my therapy session on October 22, 2018 I wrote:

PATIENT: *I feel like there’s a buried self within me. Another self that is outside of my awareness. I seem in a desperate plight to get in touch with that buried self. It’s as if I have a kind of treasure within me that’s buried and in a locked box. And I don’t have access to it. But I desperately want to get to the locked box and open it.* And I’m struck by the fact that psychoanalysis – the technical aims of psychoanalysis – merges with my fantasy system. In psychoanalysis the idea is to get in touch with the unconscious: the world of unconscious feelings and experience. The thing in psychoanalysis is to get in touch with the part of the self that is warded off from consciousness. And in my fantasy system there is this locked box that is buried inside me – like a treasure, it’s as if I feel I have a treasure buried inside me. [Again, as at the outset of the session, I express a

struggle between a conscious, observing “I” that seeks access to a mute “he” (a locked box) that lies beyond conscious awareness.

Possible Oedipal Meaning. My mother used to cook eggs and lox on Sunday mornings. I loved that. I associate eggs and lox with my mother. Also “eggs” is a female symbol. My father got to have the “female” of the house (my mother) who was denied to me; in the dream my father got to eat the eggs, which were denied to me. As a child, did I view my father’s matrimonial prerogatives (possession of his wife) as an act of “selfishness” on my father’s part? Did I want exclusive possession of my mother in place of my father? Recall my earlier observation “that the following predicate thinking [might apply]: salmon, ‘pink and moist,’ vagina, lox, locks.”

This Oedipal interpretation is consistent with my construction (The Dream of the Intruding Doctor) of my childhood scarlet fever. At age three I contracted scarlet fever, which was attributed to my drinking spoiled milk from a baby bottle. My pediatrician ordered my parents to confiscate the bottle and force me to drink from a cup. I had speculated that the baby bottle may have been a transitional object for me that was invested with fantasy: an object that was *part me* and *part non-me*. I see parallels between my probable anger at my father (and the pediatrician) at age three in confiscating my transitional object and my anger in the dream about my father “confiscating” the one meal of eggs and lox in the restaurant. Note the following symmetry: The baby bottle, as transitional object, was a derivative of mother or mother’s breast. The dream image of the meal of eggs and lox (“vagina”) apparently symbolized mother. In the dream, my father confiscated the meal of eggs and lox; at age three my father confiscated my baby bottle (a transitional object); and in the Oedipal situation my father “confiscated” my mother.

“Guilt was for Freud, and remains for much of psychoanalytic theory, the

fear of an inner policeman, formed by one's experience with a threatening parent, representing, in however distorted a form, the threats of that parent, and fueled by one's own hate." Friedman, M.I., "Toward a Reconceptualization of Guilt." This guilt, Freud said, "is derived from the Oedipus complex and was a reaction to the two great criminal intentions of killing the father and having sexual relations with the mother." This sense of guilt is derived from the tension between the harsh superego and the ego.

Contemporary conceptualizations recognize that unconscious guilt may have various sources. Arnold Modell proposed that there is "in mental life something that might be termed an unconscious bookkeeping system, i.e., a system that takes account of the distribution of the available "good" within a given nuclear family so that the current fate of other family members will determine how much 'good' one possesses. If fate has dealt harshly with other members of the family the survivor may experience guilt." Modell also wrote about "separation guilt" which is guilt based on a belief that growing up and separating from the parents will damage or even destroy them. More generally, separation guilt is guilt based on a belief that evolving one's own autonomy, having a separate existence, a life of one's own, is damaging to others. See, Friedman.

Modell attempted to explain the phenomena of survivor and separation guilt by placing them in a biological context. Invoking the evolutionary biological model of group selection Modell suggested that these forms of guilt are metaphorical extensions of an inherited altruistic impulse to share food with other members of one's group. "The altruistic impulse to share food promotes the survival of the group. The alternative would be survival of a few of the stronger individuals who would greedily hoard the available food supply, but, as has been observed, there is a survival value in maintaining the group rather than the isolated individual. It is reasonable to suppose that evolution might favor the survival of those individuals who experience guilt when they behave greedily and that the

guilt leads to the prohibition of the wish to have everything for oneself. This form of guilt, which in man's earlier history contributed to the survival of the group, continues to be inherited and continues to exert its influence upon modern man, although its original function may no longer be relevant. However, due to man's capacity for metaphorical thinking, the experience of guilt did not remain limited to its original objects, i.e., the obtaining of food, because food can be symbolically elaborated as the acquisition of that which is 'good'." Modell, A. H. "The Origin of Certain Forms of Pre-oedipal Guilt and the Implications for a Psychoanalytic Theory of Affects."

In some sense the dream can be seen as a conflict between two hoarders of food. In the dream I saw my father as hoarding the one breakfast of eggs and lox; yet, I too, had the selfish impulse to hoard the breakfast and deny my father the meal. This conflict raises issues of survivor (and separation) guilt as distinguished from Oedipal guilt.

6. Both Henry IV and his son Henry V, two Shakespearean characters, were English kings of the House of Lancaster. Burt Lancaster might symbolize the House of Lancaster.

7. Perhaps the pine trees are phallic-sexual imagery.

8. The dream image of the Vermont Avenue Apartments relates to the event of the previous day: my encounter with Dr. Ceaser in the mail room of my apartment building. The now-demolished Vermont Avenue Apartments, which I recalled from childhood, might symbolize coworker Raben and Dr. P-, two persons from my past whom I valued but who were now lost to me. The fact that I seemed pleased in the dream by the new apartment building that replaced the Vermont Avenue Apartments suggests my satisfaction with my current primary care doctor, Dr. Simons, who replaced Dr. P-. In fact, I like Dr. Simons. Also, I note that

Vermont translates as “Green Mountain,” which also relates to Greensboro, North Carolina, where Raben grew up.

9. The eldest of the four Lischin brothers (Henry Lischin), grandsons of Mrs. Blum, drowned in 1978. He had been disabled by his Korean War service. I am reminded of the famous line from Henry V’s St. Crispin’s Day speech exhorting his brothers-in-arms to battle at Agincourt: “From this day to the ending of the world [i.e., *From Here to Eternity*], But we in it shall be rememberèd— We few, we happy few, we band of brothers.” See ¶2(c), above.

In early August 1989 I had dinner with Jesse Raben and his roommate at a Chinese restaurant. At the end of the evening, I said to Raben, “We’re friends, now, right, Jesse?” He said, “Always, Gar, always (*From Here to Eternity*).” In self psychological terms, Raben was a restitutive selfobject who satisfied my narcissistic needs for mirroring, idealization and twinship (“blood brotherhood”). Did I unconsciously view Raben and me as members of a brotherhood, a “band of brothers?”

10. One of the Lischin brothers, Roy, worked as a mail carrier. Does this relate to Dr. Ceaser and the mail boxes in my apartment building?

A memory from age eleven is crucial. I recall that in early July 1965 my father and I went to Atlantic City together. My mother and sister stayed home. On the first evening in Atlantic City my father and I walked to Louis Tussaud’s Wax Museum on the boardwalk. The facade of the wax museum was Tudor in style — reminiscent of the Elizabethan period in English history, the age of Shakespeare. The Tudor facade of the wax museum calls to mind Shakespeare’s Globe Theater in London. Roy Lischin walked with us on the boardwalk. He kept singing the following song: “I’m Henery the Eighth, I Am,” a popular song from 1965. The

wax museum featured a wax statue of Henry VIII; a photograph of the wax statue of Henry VIII adorned the cover of a brochure distributed by museum. I loved the wax museum, which I visited every year.

Also, I associate Roy Lischin with Freud.

In a blog post dated July 1, 2018 I wrote:

In July 1965, when I was eleven years old, my father and I stayed with the Lischins for a week at their house on Oriental Avenue in Atlantic City. In June 1965 my sister graduated from high school and got a summer job at Temple Law School. My mother stayed at home with my sister.

My sister and Roy Lischin were starting college that fall. I have a peculiar recollection.

Roy had purchased some books he would be reading in his college courses that fall. He wanted to read them to be ahead of the game when he started at Rutgers that fall. Roy and I were sitting on the front porch at Oriental Avenue. Roy was reading a book by Freud. I don't remember which book it was, but it may have been *The Future of an Illusion*, which contained Freud's speculations about religion. I asked to see the book and I started to read the first page. I said to Roy, "I understand this." Roy said: "You don't understand that. You may understand the words, but you don't know what he's talking about." Ethel Blum, Roy's grandmother, came out on the porch. Something we were talking about clued Mrs. Blum into the fact that we were talking about Freud. She mentioned that Freud was Jewish. I don't think Roy knew that. Or he pretended not to know that.

11. Association of Atlantic City with Shakespeare. I suspect that I unconsciously associate the figures I saw in the Atlantic City wax museum

as a child – wax statues of historical persons attired in period costumes – with the gallery of characters of a Shakespeare play. This points to the possible importance of the theme of death. Wax figures resemble embalmed corpses. Perhaps the following issues are related in the dream: (1) my anxiety about seeing my primary care doctor the following day, April 23 (Shakespeare’s birthday) for the treatment of heart-related concerns; thoughts about the coronary arteries (my father died of coronary artery disease); and the corpse-like wax figures of the Atlantic City wax museum. Recall also the yahrzeit candle: a memorial wax candle that is lit in memory of the dead in the Jewish religion.

The following brief excerpt from my book, *Significant Moments* apparently parallels several issues in The Dream of Eggs and Lox, and may point to an important subtext of the dream that is blocked out in the manifest content, but might be hinted at in my dream associations to the Shakespeare characters, Prince Hal (*Henry V*) and his father, Henry IV: namely, introjective concerns in their manifold expression relating to depressive states associated with disruptions in self-definition and personal achievement; a sense of guilt and loss of self-esteem during the Oedipal stage; perfectionism, competition and the need to compensate for failing to live up to the perceived expectations of others or inner standards of excellence; and in which the paramount concern is to establish an acceptable identity – an entity separate from and different than another, with a sense of autonomy and control of one’s mind and body, and with feelings of self-worth and integrity, a self that is acknowledged, respected and admired by others.

The following text from *Significant Moments*, a book I completed in about the year 2004, presents an emotionally distressed individual having a

conversation with *an imaginary friend* (think of Dr. P-, whom I met in 2015) *on the beach* (think of Atlantic City) about his career failures. Compare the Dream of the Family Gathering that seems to concern two parents' admiration for a successful son. This excerpt from *Significant Moments* raises issues of thwarted ambition and the failure to make a place for oneself in the world, and might amplify a latent introjective content of the dream. According to Sigmund Freud, the latent content of a dream, as disclosed in the dreamer's associations, is the hidden psychological meaning of the dream.

Might my dream associations to Prince Hal (Henry V) point to underlying issues of ambition and career strivings? Might the manifest dream perhaps defend against unconscious anxiety surrounding my failure to fulfill the ambitions of my father (as symbolized by the father figure, Henry IV); or my neurotic inhibitions about surpassing my father; or, then too, possible anxieties about the subordination of my life's work, ambition, dedication, and achievement to the libidinized expectations of my father which I might experience as an ego-dystonic submissive and passive adaptation? See, Blos, P. "Freud and the Father Complex."

Permit me a digression at this moment. Peter Blos observed: "I shall cite a male student whose vocational ambitions were the same as those which his father had set for his son. Failure had to prevent success because of a four-pronged conflict: as a success he was either offering himself as a love object to the father (castration wish), or he was annihilating him by usurping his position (parricide); on the other hand, as a failure he was renouncing his ambitions and thereby induced the father to treat him like a contemptible woman; yet, in failure he also established his autonomy, even if a negative one, by repulsing the father's seductiveness, by not becoming his best-loved, ideal son. The complexity of this constellation is due to the fact that both the positive and negative Oedipus complex come

into play again at the terminal phase of adolescence.” Blos, P. “The Genealogy of the Ego Ideal.”

Similarly, Erik Erikson describes the interesting mechanism of the choice of a negative identity, an identity perversely based on all those identifications and roles which, at critical stages of development, had been presented to the individual as most undesirable or dangerous and yet also as most real. For Erikson the choice of a “negative identity” represents “a desperate attempt at regaining some mastery in a situation in which the available positive identity elements cancel each other out. The history of such a choice reveals a set of conditions in which it is easier to derive a sense of identity out of a total identification with that which one is least supposed to be than to struggle for a feeling of reality in acceptable roles” Erikson, E., *Identity and the Life Cycle*.

Let us revisit “The Dream of the Family Gathering” that I set out at another point in this book.

I am at the house where I grew up. There is a large family gathering at which my parents are present. Dr. P- is there. I am happy to see him, but I don't want to look too excited. My family treats him like a beloved son. My family ignores me; they appear to shun me. All their attention is focused on Dr. P-. Dr. P- ignores me also; he won't make eye contact. He seems happy and profoundly content. I have strong feelings of sadness and distress about Dr. P- ignoring me and my family ignoring me. I feel that Dr. P- has usurped me. I feel like an outsider in my own family. The family leads him into the kitchen, while I gaze on.

In that dream, Dr. P- was my father's best-loved, ideal son. I stood off to the side. I had feelings of dejection and sadness – but I also established my autonomy. These thoughts reveal a possible hidden aspect of the dream. It's as if in the dream I am saying, “You, Dr. P-, are a homosexual. Unlike me, you were unable to repulse your father's seductiveness. (“The family leads him into the kitchen”~ the place for women.) Am I not

saying, "Dr. P., unlike you, I am a failure, but at least I warded off castration. Have fun in the kitchen."

Early in this letter I referred several times to the playwright, Arthur Miller. I am reminded of a central conflict in Miller's Death of a Salesman: The father, Willy Loman both loves and hates his ne'er-do-well son, Biff because Biff was Willy's hope for a vicarious success in life, but Biff let him down. A dramatic parallel might be seen in Shakespeare's Henry IV, Act IV, Scene 4: Learning that Prince Hal is spending the evening in London with his rascally friends — Falstaff and company — Hal's father, Henry IV laments his son's waywardness. One might say that Prince Hal in Henry IV repulsed the ambitions which his father had imposed on his son, setting himself up for possible failure, but at the same time establishing his autonomy. Cf., Blos, P., "The Genealogy of the Ego Ideal," citing Kris, E., "Prince Hal's Conflict." Blos, referring to "Prince Hal's flight from royal dignity at the court to the carousal at the tavern[]," points out "that through the peer relationship the 'tie of dependence is broken' and a 'recathexis of the ego ideal for which the father stood' is made possible. [One author] calls this the 'renewal' of the ego ideal and defines it 'as the rescue and reaffirmation of the ego ideal — a sublimation of the love for the father.' . . . Falstaff, a split-off father imago, with the peer world, his drinking companions, reconstitute a proxy family which — by a grand detour — assists the troubled youth in the formation of the mature ego ideal and the assumption of his princely identity." Blos, P. "The Genealogy of the Ego Ideal." "All along his bewildering actions, Prince Hal never loses touch with his inner struggle. The consolidation of the ego ideal lies at the center of this struggle, in which he first fails, but finally succeeds by reconciling the idealized father imago he loves with the imperfect, if not downright evil, father person he hates." *Id.* Intense ambivalent feelings toward his father lie at the heart of Prince Hal's conflict.

I also wonder about the possible Kleinian depressive anxiety underlying this dream. The manifest dream expresses my feelings of sadness and distress. Does this manifest "sadness and distress" disclose remorse for my unconscious aggressive impulses directed against Dr. P-, namely, my unconscious feelings of hatred and jealousy of him as a young medical doctor with a successful career and happy home life? For Klein, the Oedipus complex and the depressive position are closely linked.

Be that as it may.

Returning to my novel *Significant Moments*, what follows is a passage of the text that talks about career strivings, career failure, autonomy – and features an interaction with an idealized, imaginary friend:

What does *paramita* mean? It is rendered into Chinese by "reaching the other shore." Reaching the other shore means detachment from birth and death. Just because people of the world lack stability of nature, they find appearances of birth and death in all things, flow in the waves of various courses of existence, and have not arrived at the ground of reality as is: all of this is "this shore." It is necessary to have great insightful wisdom, complete in respect to all things, detached from appearances of birth and death—this is "reaching the other shore."

It is also said that when the mind is confused, it is "this shore." When the mind is enlightened, it is "the other shore." When the mind is distorted, it is "this shore." When the mind is sound, it is "the other shore." If you speak of it and carry it out mentally, then your own reality body is imbued with *paramita*. If you speak of it but do not carry it out mentally, then there is no *paramita*.

Commentary on the Diamond Sutra.

" . . . I have had many thoughts, but it would be difficult for me to tell you about them. But this is one thought that has impressed me, . . .

Hermann Hesse, *Siddhartha*.

. . . my friend.

William Shakespeare, *Two Gentlemen of Verona*.

Wisdom is not communicable. The wisdom which a wise man tries to communicate always sounds foolish."

"Are you jesting?"

Hermann Hesse, *Siddhartha*.

. . . his friend asked.

Henry James, *The Lesson of the Master*.

"No, I am telling you what I have discovered. Knowledge can be communicated, but not wisdom. One can find it, live it, be fortified by it, do wonders through it, but one cannot communicate and teach it. . . ."

Hermann Hesse, *Siddhartha*.

He sank into a reverie and became lost within himself.

Hermann Hesse, *Demian*.

He hesitated, and then . . .

Neville Shute, *On The Beach*.

. . . he continued, assuming the role of a mentor.

Arthur Rubinstein, *My Young Years*.

King Janaka, the legendary ruler of the Kingdom of Mithila in India, was once conversing on top of a hill overlooking his city with a wise Buddhist monk. The monk said, "King, look down and across the valley. Do you see those flames? Your city burns." Janaka was not perturbed. He watched quietly for a few minutes, then turned to the monk and said these words, which have been handed down for centuries in India as the quintessence of wisdom: "*Mithilayam pradipitayam, na me dahye kincana* (In the conflagration of Mithila, nothing of mine is burned)." The story is told to demonstrate detachment, and the transcendence of any sense of ownership. What was truly Janaka's (love, for example) could not be burned.

J. Moussaieff Masson, *Final Analysis: The Making and Unmaking of a Psychoanalyst*.

Where is now my wisdom in this confusion?

Richard Wagner, *Götterdämmerung*.

—In truth, . . .

The Diary of Richard Wagner 1865-1882 – The Brown Book.

I feel a little bit like Janaka without the wisdom.

J. Moussaieff Masson, *Final Analysis: The Making and Unmaking of a Psychoanalyst.*

As I look back over my development and survey what I have achieved so far, . . .

Franz Kafka, *A Report to an Academy.*

. . . both in the university and in the professional world of psychoanalysis, I see flames, and the consumption of my life's work. My bridges are truly burned. But while I feel any kind of sadness and a nostalgia for what might have been, I cannot truly say that I am sorry for the loss.

J. Moussaieff Masson, *Final Analysis: The Making and Unmaking of a Psychoanalyst.*

He paused.

Bram Stoker, *The Man.*

What might have been is an abstraction

Remaining a perpetual possibility

Only in a world of speculation.

What might have been and what has been

Point to one end, which is always present.

T.S. Eliot, Excerpt from “*Burnt Norton.*”

He begins to read, then lets it slip from his fingers, leans back, picks reflectively at . . .

Simon Grey, *Butley.*

. . . particles of sand . . .

Charles Darwin, *The Voyage of the Beagle.*

. . . On the Beach.

Neville Shute, *On the Beach.*

There was another place . . .

Richard Wilbur, Excerpt from “*Someone Talking to Himself.*”

. . . I have forgotten

And remember.

T.S. Eliot, Excerpt from “Marina.”

He paused again, dreaming, lost in a reverie, then just above a whisper, murmured:

Frank Norris, *The Octopus.*

some other place—

George Eliot, *The Lifted Veil.*

fuck . . . Where?

Simon Grey, *Butley.*

By the hallowed . . .

Johann Wolfgang von Goethe, *Faust* (Part II) (Final Scene).

... inner sanctum, . . .

Arthur Conan Doyle, *The Lost World.*

... at the portal . . .

O. Henry, *The Headhunter.*

... to that . . .

Oliver Wendell Holmes, *The Guardian Angel.*

... last of meeting places . . .

Neville Shute, *On the Beach* quoting T.S. Eliot, “*The Hollow Men.*”

... in a world of time beyond me;

T.S. Eliot, Excerpt from “Marina.”

By the mystic arm immortal

Warning me to go my way;

By my forty years' . . .

Johann Wolfgang von Goethe, *Faust* (Part II) (Final Scene).

... material existence . . .

Nathaniel Hawthorne, *The Devil in Manuscript.*

... in this strange and savage world, . . .

Edgar Rice Burroughs, *Tarzan the Terrible.*

May I be excused for saying that I was forty years old?

Jules Verne, *20,000 Leagues Under the Sea.*

In the waste and desert land,

By the words of . . .

Johann Wolfgang von Goethe, *Faust* (Part II) (Final Scene).

... my banishment, ...

E. Phillips Oppenheim, *The Great Impersonation*.

... the sentence,

Traced in parting, on the sand—

Johann Wolfgang von Goethe, *Faust* (Part II) (Final Scene).

(*after a pause*).

Simon Gray, *Butley*.

So long ago!

Frances Hodgson Burnett, *T. Tembarom*.

There is a silence.

Simon Grey, *Butley*.

Since you ...

Lucy Maud Montgomery, *The Golden Road*.

... miscall'd the Morning Star,

Nor man nor fiend hath fallen so far.

George Gordon, Lord Byron, Excerpt from “*Ode to Napoleon Buonaparte*.”

“I suppose you might say that . . .”

P.G. Wodehouse, *Right Ho, Jeeves*.

You played . . .

Thomas Hardy, *A Pair of Blue Eyes*.

... an intellectual game for high stakes, . . .

Peter Gay, *Freud: A Life for Our Times*.

... And you lost

Bret Harte, *The Three Partners*.

That my friend, . . .

Jeffrey Farnol, *The Broad Highway*.

... was your fate, and that your daring.—

The Diary of Richard Wagner 1865-1882 - The Brown Book.

‘I—suppose so.’

Thomas Hardy, *A Pair of Blue Eyes*.

Two parts of himself were having a conversation. You were

probably meant to think of yourself as 'I' when talking to yourself.

Jack Grimwood, *Moskva*.

I was an experiment on the part of Nature, a gamble within the unknown, perhaps for a new purpose, perhaps for nothing, and my only task was to allow this game on the part of primeval depths to take its course, to feel its will within me and make it wholly mine.

Hermann Hesse, *Demian*.

(*Pause.*) Perhaps my best years are gone. When there was a chance of happiness. But I wouldn't want them back. Not with the fire in me now. No, I wouldn't want them back.

Samuel Beckett, *Krapp's Last Tape*.

As I look back now, it seems to me I must have had at least an inkling that I had to find a way out or die, but that my way out could not be reached through flight.

Franz Kafka, *A Report to an Academy*.

I could see he was talking about things he had brooded on for a long time and felt very strongly about.

Alexander Gladkov, *Meetings with Pasternak: A Memoir*.

He paused for a moment, then continued:

Arthur Rubinstein, *My Young Years*.

Many complain that the words of the wise are always merely parables and of no use in daily life, which is the only life we have. When the sage says: "Go over," he does not mean that we should cross to some actual place, which we could do anyhow if the labor were worth it; he means some fabulous yonder, something unknown to us, something too that he cannot designate more precisely, and therefore cannot help us here in the very least. All these parables really set out to say merely that the incomprehensible is incomprehensible, and we know that already. But the cares we have to struggle with every day: that is a different matter.

Concerning this a man once said: Why such reluctance? If you only followed the parables you yourselves would become parables and with that rid of all your daily cares.

Another said: I bet that is also a parable.

The first said: You have won.

The second said: But unfortunately only in parable.

The first said: No, in reality: in parable you have lost.

Franz Kafka, *On Parables*.

When he finished talking, . . .

Hermann Hesse, *Siddhartha*.

. . . his companion, . . .

Rudyard Kipling, *Kim*.

. . . an imaginary companion . . .

Virginia Woolf, *Night and Day*.

. . . to be sure, . . .

Friedrich Nietzsche, *Beyond Good and Evil*.

. . . both ideal self and . . .

Eleanor Stump, *Wandering in Darkness: Narrative and the Problem of Suffering*.

. . . fantasized "Other" . . .

Nihan Yelutas, *Otherness Doubled: Being a Migrant and "Oriental" at the Same Time*.

. . . but no less . . .

Thomas Hardy, *A Pair of Blue Eyes*.

. . . his intimate and beloved companion . . .

Dorothy T. Burlingham, *The Fantasy of Having a Twin*.

. . . directed his somewhat weakened glance at him.

Hermann Hesse, *Siddhartha*.

It was very quiet then.

David Evanier, *The Man Who Refused to Watch the Academy Awards*.

A volley of the sun . . .

Richard Wilber, Excerpt from "*Someone Talking to Himself*."

. . . shone down on them out of a cloudless sky, warm and comforting;

Neville Shute, *On The Beach*.

. . . Siddhartha sat absorbed, his . . .

Hermann Hesse, *Siddhartha*.

... clouded mind in a flash of illumination became an open mind: vast like the ocean and the sky.

Yes, the eyes . . .

Siegfried Hessing, *Prologue with Spinozana—Parallels via East and West in Speculum Spinozanum 1677-1977*.

. . . his eyes far away yet gleaming like stars, . . .

Cosima Wagner's Diaries (Tuesday, October 31, 1882).

. . . staring as if directed at a distant goal, the tip of his tongue showing a little between his teeth. He did not seem to be breathing. He sat thus, lost in meditation, thinking Om, his soul as arrow directed at Brahman.

Hermann Hesse, *Siddhartha*.

Then, quite unheralded, came the following cry from the heart:

Martin Gregor-Dellin, *Richard Wagner: His Life, His Work, His Century*.

"Why is it that you have not done great things in this world? With the power that is yours you might have risen to any height. Unpossessed of conscience or moral instinct, you might have mastered the world, broken it to your hand. And yet here you are, at the top of your life, where diminishing and dying begin, living an obscure and sordid existence, . . . reveling in a piggishness, to use your own words, which is anything and everything except splendid. Why, with all that wonderful strength, have you not done something? There was nothing to stop you, nothing that could stop you. What was wrong? Did you lack ambition? Did you fall under temptation? What was the matter? What was the matter?"

Jack London, *The Sea Wolf*.

He found it difficult to think; he really had no desire to, but he forced himself.

Hermann Hesse, *Siddhartha*.

He lifted his eyes to me at the commencement of my outburst, and followed me complacently until I had done and stood before him

breathless and dismayed. He waited a moment as though seeking where to begin, and then said, "[Friend], do you know the parable of the sower who went forth to sow? If you will remember, some of the seed fell upon stony places, where there was not much earth, and forthwith they sprung up because they had no deepness of earth. And when the sun was up they were scorched, and because they had no root they withered away. And some fell among thorns, and the thorns sprung up and choked them."

"Well?" I said.

"Well?" he queried, half petulantly. "It was not well. I was one of those seeds."

Jack London, *The Sea Wolf*.

Therapy Session: October 22, 2018

What we conceive of as an unbroken thread of consciousness is instead quite often a train of discontinuous fragments. Our awareness is divided. And much more commonly than we know, even our personalities are fragmented—disorganized team efforts trying to cope with the past—rather than the sane, unified wholes we anticipate in ourselves and in other people.

— Martha Stout, *The Myth of Sanity: Divided Consciousness and the Promise of Awareness.*

Two parts of himself were having a conversation. You were probably meant to think of yourself as 'I' when talking to yourself.

— Jack Grimwood, *Moskva.*

In this session my thoughts about dissociated states arose in the context of a depressed mental state.

PATIENT: So, I was thinking about our relationship. I think we're on two different tracks. It's as if I'm on one track and you're on another. I talk about things from one perspective, and it's as if the things you say don't match up with what I am saying. We seem to talk at cross purposes. I was thinking about that question you've asked several times: "Why do I come here?" I think about that and fundamentally I don't know why I come here. Maybe I come here out of habit or a sense of duty, as if I have to come here. I think that maybe I have two different selves. One self is in psychological pain and needs some type of therapy. And another self coerces me to come here because it knows that the part of me in treatment needs help. In that sense it's a kind of a sense of duty.

[So, I was thinking about our relationship. I think we're on two different tracks. It's as if I'm on one track and you're on another. I talk about things from one perspective, and it's as if the things you say don't match up with what I am saying.

We seem to talk at cross purposes. I was thinking about that question you've asked several times: "Why do I come here?" I think about that and fundamentally I don't know why I come here. Maybe I come here out of habit or a sense of duty, as if I have to come here. I think that maybe I have two different selves.

These opening comments are striking and can be read with an ironic gloss. Manifestly, I am speaking to my therapist: I am talking about my relationship with her. Yet, can we not imagine that these thoughts are actually a conversation between two parts of myself? The "you" I am addressing can be seen as a dissociated fragment of my "I." I am having a conversation with myself (that is, with "him") – not with my therapist. The statements can be seen as utterly solipsistic.

The division of the self into multiple identities is a hallmark of dissociation. The hesitations and doubts I express in these opening comments combined with the obvious split between the "I" who makes a conscious decision to come to therapy and the mute "he" that is in psychological pain calls to mind Searles' observations about a patient who exhibited at the start of a session a self-reflective posture in which one aspect of the self observed and reflected upon others that were formerly dissociated.

Searles writes: *It may not be deeply significant if a patient occasionally begins a session with the statement, "I don't know where to begin." It may be simply a realistic attempt to cope with, for example, the fact that much has been happening with him of late. But I began to realize some two years ago that the patient who more often than not begins the session with this statement (or some variation upon it) is unconsciously saying, "It is not clear which of my multiple 'I's will begin reporting its thoughts, its feelings, its free associations, during this session." That is, it is not basically that there are too many competing subjects for this "I" to select among to begin the reporting, but rather that there are too many "I's" which are at the moment, competing among "themselves" as to which one shall begin verbalizing. . . . A woman, who had become able, over the course of her analysis,*

to integrate into her conscious sense of identity many previously warded-off part identities, began a session by saying, in a manner which I felt expressive of much ego strength, in a kind of confident good humor, "Now let's see; which one of my several identities will materialize today?" See, Bromberg, P.M. "Standing in the Spaces: The Multiplicity of Self and the Psychoanalytic Relationship."]

PATIENT: I feel like a robot. I just act out of routine. I am a robot. I come here every week because that's what I do. But that's no different from how I live my life generally. I'm a robot in my daily life outside of therapy. I just go on from day-to-day out of routine. I do the same things every day. I guess to some extent I'm happy with that. It doesn't matter to me that I live like a robot. But that's not mental health. A few of my past therapists have said, "You seem content. You seem content with your life." I guess you could say that in a certain sense. But if I am content, it's a particular type of contentment. I think of a metaphor for how I feel. It's like I'm a terminal cancer patient in a hospital and I'm on morphine. So, yeah, I feel no pain. And I guess I'm kind of content in that sense, that I feel no pain. But that's not contentment. How can anyone say that's contentment? See dream interpretation at Appendix A to this letter, which mentions a terminal cancer patient.

[The cancer patient metaphor is, once again, an expression of a dissociative state: a division of the self between an observing "I" that feels no pain and a mute "he" that struggles with a terminal illness.]

PATIENT: The absence of symptoms is not health. Just because you don't have symptoms doesn't mean you're healthy. I feel like there's a buried self within me. Another self that is outside of my awareness. I seem in a desperate plight to get in touch with that buried self. It's as if I have a kind of treasure within me that's buried and in a locked box. And I don't have access to it. But I desperately want to get to the locked box and open it. And I'm struck by the fact that psychoanalysis – the technical aims of psychoanalysis – merges with my fantasy system. In psychoanalysis the

idea is to get in touch with the unconscious: the world of unconscious feelings and experience. The thing in psychoanalysis is to get in touch with the part of the self that is warded off from consciousness. And in my fantasy system there is this locked box that is buried inside me – like a treasure, it's as if I feel I have a treasure buried inside me.

[Again, as at the outset of the session, I express a struggle between a conscious, observing "I" that seeks access to a mute "he" (a locked box) that lies beyond conscious awareness.

At an earlier session I talked about myself in terms of "tarnished silver." I said that there was a core self within me made of shiny silver, underneath the tarnish. The purpose of psychoanalysis is to clean off the tarnish, I said. My thoughts at this session about a "treasure buried within a locked box" inside me seems to be a related image.

At that earlier session, I talked about my friend Craig and compared him and me in the following terms: I said that Craig and I were both silver, but that in the case of Craig, there was no tarnish—the silver gleamed. I too am silver, but I am covered in tarnish and the gleam is obscured.

The fantasy of hidden or buried identities is prominent in schizoid disorder. Doidge, N. "Diagnosing the English Patient: Schizoid Fantasies of Being Skinless and of Being Buried Alive." "Schizoid withdrawal is not only interpersonal, i.e., away from real people; there is a kind of intrapsychic withdrawal, based upon fantasy. As treatment progresses, it is not uncommon for the schizoid to reveal fantasies of having buried his self within him, where it lies waiting until it is safe to be exposed."

The psychoanalyst Frank Summers has interesting observations about the patient's "buried self" and the "transitional space" of the therapeutic setting:

"From the theoretical perspective of object relations theory, personality development means the unblocking of arrested self-potential. To allow the *buried self* to become articulated, the analytic relationship must provide the maximum possible space for self-expression. From this viewpoint, because the task is to provide the patient the best possible opportunity to unblock self-arrestation, the analyst's posture is defined by the provision of a space that allows the old modes of being to give way and promotes the creation of a new self-structure. If previously *buried parts of the self* are to emerge, an object must be related to in a new way, created in a manner that fits the needs of the patient.

Here we can identify Winnicott's conception of analytic space as an intermediate area between the reality of who the analyst is and the patient's fantasied projections. This space is limited by the analyst's reality but offers the possibility for the patient to experience this reality in a variety of ways and create new meanings within the givens of the analytic setting. Such an analytic stance is not blank because it offers the patient a particular kind of environment, but within these limits, it attempts to provide the maximum space possible for the patient's self to gain expression through a new relationship with the analyst. "Psychoanalytic Boundaries and Transitional Space."

My notion that psychoanalysis (a venture that permits the creation of a transitional space between analyst and patient) promises access to my buried self seems related to the idea that, in a more general sense, transitional phenomena – and by extension, selfobject experience (such as my fantasied relationship with Dr. P–), as well, offers access to my buried self. What I am saying is that all of the following objects are cognates for me: psychoanalysis, transitional phenomena, creativity (writing), and selfobject experience (that is, fantasies about or interactions with people like Dr. P–).]

[At another point in the session I said:

PATIENT: What I am looking for here is some recognition. I am wishing you would say, "I have worked with patients like you before. They talk about the issues you talk about and I know what is going on with them. I recognize your problems." I wish you could look at the things I am talking about and think about how my concerns cluster with other issues in similar patients – and come up with an idea of what is going on with me. I am looking for a sense of recognition from you.

THERAPIST: You usually give the impression you don't want anything from me. But today you are talking about wanting something from me.

PATIENT: Yes, I am talking about wanting something from you. I am looking for a sense of recognition.

[I have the sense that the therapist is confusing my narcissistic need for recognition (mirroring, essentially) with object need, or a need for attachment. I am not expressing a need for attachment in the sense that Bowlby talks about it; I am expressing a need for mirroring as Kohut talks about it.

My sense is that I was experiencing a sense of alienation with the therapist, that I felt so different from her and her other patients, that she could not recognize my fundamental identity. I was experiencing a subjective "I" in relation to an alien "other," as if I spoke one language and she spoke another. Symbolically, I was saying: "Do you have other patients who speak my native language?" It's as if I was saying, "I need a translator" or "I need some sense that you understand my language." I had the sense that the therapist was turning my sense of alienation into an anaclitic concern about my "wanting something" from her.

The therapist's attribution of a state of "wanting something from her" is

noteworthy. Keep in mind that *envy* is a state of "wanting." Was the therapist experiencing envy of me at this session? Was the therapist unconsciously saying, "I envy you. I feel diminished in relation to you: I feel shame in relation to you. And I need to believe that it is *you* who want something from me." In the past week I had given the therapist two email messages I had received from (1) the chairman of the psychology department at UC-Berkeley as well as (2) a professor at the Johns Hopkins University Department of Psychiatry that had praised writings I had submitted to them. At an earlier session (May 29, 2018) in which I had told the therapist that a leading expert in attachment theory at UC-Davis (Philip Shaver, Ph.D.) had responded with in-depth thoughts about my writing, the therapist said at one point: "You think you're smarter than everybody else."]

[At a later point:]

THERAPIST: You seem in low spirits today. You seem distant and distracted in a way that you didn't at past sessions.

PATIENT: Yes, I am. I feel distant and distracted. I was on an emotional high the last few weeks talking about my primary care doctor, Dr. P-. The last few sessions were a kind of arc, one session after another continuing with different aspects of my thoughts and feelings about Dr. P-. My thoughts about him inspired me in my therapy work. And now it's all gone. I feel I have nothing more to say about Dr. P- and I feel drained and without inspiration.

THERAPIST: Thoughts about your doctor inspired you.

PATIENT: Yes. It gave me ideas to think about. You know, it's as if I am a scriptwriter for a TV series and I created this really entertaining story line that I explored in a series of episodes. And then in one episode I killed off the main character and so, that's the end of that story arc. There's nothing

more to write about that story line. And I have to come up with a new story line. I feel that way in therapy. That we talked about things that inspired me in the past few weeks and I explored those ideas and now I have run out of ideas. And I have to come up with something to talk about.

[The metaphor of the scriptwriter is, again, a reference to a dissociative state. The metaphor alludes to my sense of a "superordinate self" – the conscious "I" – that, in fact, encompasses "a gallery of characters," that is, a multiplicity of selves. My sense is that my mental functioning occupies a borderline state between, on the one hand, a healthy multiplicity of selves, and, on the other, a state of pathological fragmentation and conflict – an agglomeration of incompatible selves torn by antagonistic wishes and needs. I refer to another passage from Bromberg's paper, which explores the spectrum of dissociative states ranging from the "multiplicity of selves" of "well-put-together individuals" all the way to states of "disintegration, fragmentation, or identity diffusion" found in persons with notable character pathology:

Multiple versions of the self exist within an overarching, synthetic structure of identity . . . [which] probably cannot possess the degree of internal cohesion or unity frequently implied by concepts such as the "self" in the self psychological tradition, the "consolidated character" in Blos's ego psychological model, or "identity" in Erikson's framework. . . . [T]he idea of an individual "identity" or a cohesive "self" serves as an extremely valuable metaphor for the vital experience of relative wholeness, continuity, and cohesion in self-experience. Yet, as has often been noted, when we look within the psyche of well-put-together individuals, we actually see a "multiplicity of selves" or versions of the self coexisting within certain contours and patterns that, in sum, produce a sense of individuality, "I-ness" or "me-ness" Although the coexistence of "multiple versions of the self" that we observe introspectively and clinically may thus represent crystallizations of different interactional schemes, this multiplicity may also signal the existence of an inner, functional limit on the process of self-integration. . . . The cost of our human

*strategy for structuring the self in a provisional fashion—around a sometimes precarious confederation of alternate self/other schemas—**lies in the ever-present risk of states of relative disintegration, fragmentation, or identity diffusion.** The maintenance of self-cohesion . . . should thus be one of the most central ongoing activities of the psyche. . . . [but] . . . the strivings of such an evolved “superordinate self” would emanate . . . not primarily from a fragmentation induced by trauma or environmental failure to fully provide its mirroring (selfobject) functions. Rather, its intrinsic strivings would emanate from the very design of the self-system. See, Bromberg, P.M. "Standing in the Spaces: The Multiplicity of Self and the Psychoanalytic Relationship" quoting Slavin, M.O. and Kriegman, D. *The Adaptive Design of the Human Psyche.*]*

THERAPIST: You feel you need to entertain me.

[The therapist here focuses on the relationship between her and me. Her formulation is interpersonal, or anaclitic. "*The patient feels he needs to entertain me.*"]

PATIENT: Not precisely. I feel I need to be entertaining. I feel I have to do that. That I am an entertainer. I have to entertain people. I have to be entertaining in therapy. That's my duty.

[Here, I focus on the introjective angle. It's not that I need to entertain *another person*, as the therapist projected onto me from her anaclitic perspective. My focus is on my perceived need to carry out a task: to be an entertainer. Recall my statement at the outset of the session: “I feel a duty to come to therapy,” that is, I feel a robotic need to come to therapy, as if I feel an inner need to perform an inner-directed task.]

PATIENT: You know, your orientation is so people-oriented. I just don't think in those terms. I don't usually think about other people in situations that other people think about people. That reminds me of an anecdote. Can I tell you about that? I was going away to college. So I had

a chess set. My brother-in-law taught me how to play chess and we played chess. So I had this chess set. And my mother said to me: "You could take your chess set up to school with you." And I said: "Yeah, I could study chess moves." And my mother was irritated. She said, "No! I mean you could take your chess set up to school, play chess with other people, and make friends." So, she immediately thought about social issues. My mind doesn't work like that. My mind doesn't automatically go to social issues. I am extremely self-oriented. Everything is me and my inner world. Not other people.

[My comments reveal an intense self-absorption typical of schizoid states.]

PATIENT: I feel drained today. It's like post-partum depression. I lost my inspiration and I feel drained. It's like when a woman is pregnant and she looks forward all those months to having a baby, and her whole world is focused on that. See, e.g., Gowan, J.C. and Demos, G.D., "Managing the 'Post Partum' Depression in Creative Individuals."

[The pregnant woman is actually two people, two selves: mother and fetus. Thus, the pregnant woman can be a symbol for multiplicity or dissociation. The mother contains a "treasure" waiting to be unlocked or birthed. The mother is conscious and deliberative; the fetus is the mute "he" or "she."]

PATIENT: And then the baby is born, and her whole world crashes. She has lost the thing that had given her life so much meaning. She gets depressed. I actually faced the same thing with my last therapist. I came in one day, and she noticed that I seemed depressed. I wasn't my usual self. And she noticed that. And, you know, I linked up my feelings to post-partum depression. I had just completed my book. I had been writing a book. And I completed it. And I lost all the excitement of that activity. And I felt a sense of loss. And it's interesting, because my therapist linked my depression to a social issue. She knew that I had just lost my case

manager. She said, "How long did you have that case manager?" And I said "nine years." She said that's a long time. And she went on to surmise [or project] that I probably had feelings of loss about losing my case manager. She put my feelings in interpersonal terms, but the problem was not interpersonal, and I knew that, because I knew that I was depressed about finishing my book and running out of ideas.

[Psychotherapy has been compared to the birthing process—a process that leads to the birth of the buried self. “From the viewpoint of giving birth to the buried self, the [psychotherapeutic aim] is adaptation to the patient to relinquish defenses and realize the self.” Summers, F. “Psychoanalytic Boundaries and Transitional Space.” At an earlier session I told the therapist that I viewed the therapist as a “midwife” who facilitates the birth of a new self.

It is significant that I implicitly linked my feelings about Dr. P—(who "inspired me") with my creative act of writing a book (which activity "inspired me.") That is, my feelings about a selfobject equates with my feelings about creativity (a transitional phenomenon). An association: At age three I contracted scarlet fever. My mother had indulged my taste for spoiled milk, which I drank from a baby bottle. I surmise that the baby bottle was a transitional object that I had invested with psychic significance. My pediatrician attributed my infection to my drinking spoiled milk from the bottle and ordered my mother to dispose of the bottle and force me to drink from a cup. I assume that I experienced the loss of the bottle (my transitional object) as traumatic. See dream interpretation at Appendix A to this letter. Is it possible that loss of creative inspiration in adulthood (as I described above) revives early feelings of loss and mourning that originally attached to the loss of my transitional object (the bottle)? Winnicott wrote a case study about a boy who had lost his transitional object, a small woolen toy called the Niffle, under traumatic circumstances. The boy thereafter struggled with feelings of loss and mourning. See, Winnicott, D.W. “The Niffle.”

Note also my reference to giving birth (post-partum depression). I am reminded of the so-called “secret sharer fantasy” that might have been an issue for me in my obsessive preoccupation with my former primary care doctor, Dr. P—. In the so-called “secret sharer” fantasy two creative adults influence each other through collaboration; they write for each other and share an unconscious fantasy of creating together in a sublimated sexual act. The secret sharer fantasy is a narcissistic one in which the double often represents the mother of early infancy with whom one merges and creates. It is also Oedipal in that in fantasy the relationship spawns a product – unconsciously, a baby. The Oedipal attachment might be of the negative or positive type. Perhaps, my fantasies about Dr. P— centered on my unconscious wish that I merge with him and spawn a child, which in some way may be related to Bion’s notion of the Pairing Basic Assumptions Group that centers on an unconscious group fantasy of hope that two members of a group (regardless of gender) will merge and give birth to a utopia.

Something else that seems significant: My depressed state did not center on the person of Dr. P— as a potential friend (that is, an object attachment) but on my image of him as an inspiring figure. Dr. P— had lost his evocative power for me in fantasy, and it was *that* loss that was painful for me. I suspect this distinction says something significant about my ego functioning.]

[The therapist mentioned my failure throughout my treatment to accept her feedback, or my rejection of her feedback, as if she sees her role as “feeding” me truths that I am required to absorb. My sense of the therapist is that she has an interdependent self that relies on interpersonal connections with individuals and groups to support her self-esteem. In my view, she perceives her role as therapist as rooted in her sense of herself as a *nurturer* who offers feedback that is to be absorbed by patients: a symbolic mother-infant relationship in which the infant’s feeding inures

to the narcissistic image of the mother as an all-giving breast.

Might we compare and contrast, on the one hand, the therapist's fantasy of being a nurturing mother figure, which centers on her wish for symbiotic merger with the patient via the act of feeding the infant (an act that inures to the narcissistic integrity of the therapist, one that confirms her grandiose self-image as an all-giving and bountiful breast) with, on the other hand, my fantasy of merger with Dr. P—, which centers on my wish to spawn an offspring that will bring about the dawn of a utopia? Might we surmise that *my* merger fantasy is Oedipal in nature as contrasted with the therapist's merger fantasy, which is based on a wish for infantile symbiosis? That is to say, might we speculate that in a basic assumptions group, the therapist would be sucked into the role of a narcissistic leader of a dependency basic assumptions group, while I would be sucked into the role of leader in a pairing basic assumptions group (and, incidentally, as an individualist, I would be sucked into the role of scapegoat in a fight/flight basic assumptions group)? One wonders.

I believe that my failure to accept the therapist's feedback amounts, in her mind, to the infant rejecting her breast, which she then experiences as a narcissistic injury – namely, the infant's failure to participate in mother's enactment that requires the infant to support the mother's idealized self-image as nurturer. The therapist seems routinely irritated by my failure to participate in her transference enactment, which fundamentally requires the patient to absorb her feedback – a required act by the patient that confirms the therapist's idealized (or grandiose) self-image. She experiences a patient's rejection of her feedback as injurious to her self-esteem; the patient's failure to participate in the therapist's transference enactment is thus endowed with shame.

One could also view my observations about the therapist as a projection of my own anxieties about maternal engulfment; I project onto the therapist the image of a narcissistic mother who forces her breast into the

infant's mouth to satisfy her own *need to feed* rather than gratify the infant's *need to suck*.

I think of the following: At an earlier session, the therapist asked: "What is it you feel around other people?" I said, "I feel alienated." She replied: "Let me show you how your feelings of alienation are actually feelings of fear of rejection," that is, "you feel different from others and you anticipate that you will be rejected, which arouses feelings of shame in you." The therapist's interpretation suggests that, for her, *rejection* by another is associated with *shame*. Might we infer that the therapist is unconsciously saying: "The patient who rejects my feedback fails to validate my idealized notions about myself – my grandiose identity as *nurturer* – so I feel ashamed."

In fact, the notion that a patient has an obligation to accept or *absorb* a therapist's feedback, like an infant who must imbibe mother's milk, is questionable. Summers points out:

"It must be emphasized that from the viewpoint of transitional space and adaptation, interpretations are not bearers of information to be absorbed, but offerings to be responded to as the patient needs. A good interpretation is submitted for the patient's consideration, a proposal meant to illuminate an aspect of the patient's being that the patient can use to find or create new meaning. This concept of interpretation has its analogue in the development research showing that the child uses the parental response to create meaning from the experience. The [therapist] offers the interpretation as a bit of reality the ultimate value of which is what the patient creates from it, however that might fit with the meaning intended by the [therapist]. An ineffective interpretation is an [therapeutic] offering from which the patient cannot create a meaningful experience." "Psychoanalytic Boundaries and Transitional Space."

I speculate that only an authoritarian therapist who is used to exploiting

her patients' infantile regression will obligate a patient to blind acceptance of her truths. I speculate that only an authoritarian therapist will have as a model of therapy one in which the patient is comparable to "the nascent self of the infant who is merged with and anxiously attached to the love object, mother," a situation in which infant and mother are as one. Cf., Diamond, M.A. and Allcorn, S. "The Psychodynamics of Regression in Work Groups."

It is noteworthy that at one point in the session, the therapist said: "Your sense of your uniqueness is a 'double-edged sword.' On the one hand, it boosts your self-esteem to think that you are special, but then it leads to your estrangement from others (and consequent feelings of shame)."

(*Compare: My grandiose sense of myself as a nurturing therapist is a "double-edged sword." On the one hand, it boosts my self-esteem when my regressed patients think I am special, but then it leads to feelings of shame when I work with an independent-minded patient who doesn't look on me as an all-giving, bountiful breast and who absorbs my feedback unquestioningly.*) The therapist thereby projected onto me the anxieties of an "interdependent self" who struggles with a need to belong and be accepted (perhaps, a need to engage in symbiotic merger) – by peers or by patients in a psychotherapy setting.

But the fact is I have an "independent self-concept" and not an "interdependent self." My sense of uniqueness might lead to alienation from others, but unlike interdependent persons, I do not fear alienation and I do not associate alienation with shame. "While it is true that people have a strong motivation to form and maintain relationships, the need to belong is not the only social motive nor is it always most salient. Indeed, the need to individuate has been shown to be an equal, if not stronger, motive in certain situations. For instance, individuals with an independent self-concept tend to think of themselves as separate from others and to emphasize personal goals over group goals. Such individuals have been shown to have a high need for uniqueness. An independent self-concept has been shown to blunt some consequences of rejection

including embarrassment [and shame]. These people remain less sensitive to rejection because of the reduced value placed on being part of a group. For independent selves, individuality is a positive distinction; and therefore, rejection may strengthen this sense of independence. In contrast, the motivation to fit in and maintain harmony with the group will likely drive interdependent selves to respond to rejection by engaging in reparative strategies like strengthening friendships and even mimicry to signal the desire to affiliate.” Kim, S.H. “Outside Advantage: Can Social Rejection Fuel Creative Thought?”

It seems clear that the therapist associates my failure to accept her feedback as a rejection of her as a person and, as such, my behavior is endowed with shame that is grounded in her interdependent self and her need for acceptance and validation by patients. My struggles with this therapist can be seen as a conflict between two persons who are at disparate poles of individuation. Group theory teaches that regressed group members who relinquish a portion of their autonomy and identity to a pre-autonomous group identity and look to group membership for acceptance, validation, and narcissistic integrity will attack independent persons who retain their uniqueness, namely, their “thinking, their individuality, and their rationality.” The affect underlying the attack will be envy, according to Kernberg. See, *Ideology, Conflict, and Leadership in Groups and Organizations*. It seems that the individuated patient, that is, the patient with an independent self, will always be at risk of envious attack by the interdependent therapist who seeks symbiotic merger with her patients.]

PATIENT: I want to talk about something I never talked about before. I think it's important. It's the way I respond to difficult situations. When I am in a difficult situation, in my mind, I remove myself from the situation mentally – it's as though I become a research scientist in the situation. I feel I can't escape, but I do escape mentally, by taking on the role of an observer.

It reminds me of that anecdote when I was 12 years old. I told you how I infected myself with poison ivy. I wanted to come down with a poison ivy rash, so that I could then go on to find a cure for poison ivy rash. And I had a fantasy I would be recognized as a great research scientist by my work of experimentation. It's kind of like a metaphor for what I am talking about. So there is this one person, or one identity, that is in pain; he has this poison ivy rash. But then there is this other identity that is split off – he is the observer identity, he is the research scientist. I think that has some important significance. That's not something most 12-year-old kids would do. See dream interpretation at Appendix A to this letter.

It seems like splitting or dissociation; a split between an observing ego and an experiencing ego. I think that can be a response to trauma.

When I was growing up, I was in this disturbed, dysfunctional family. And I was stuck there. I was just a kid. And this was my family. And I couldn't escape. And I wonder if I had this coping mechanism where somehow I saw myself as doing a research study in my family. It's as if I thought I wasn't really part of this family. It was like a research study where I was the scientist studying these people. So I was experiencing all these bad things, but at the same time my coping mechanism was that I was in some way mentally absent from the situation. Like an FBI undercover agent. [An FBI undercover agent might become a member of the mob, but he's really observing and gathering evidence. He's in the mob; but he's not in the mob.] I think that would be a coping mechanism. It's a way of mentally dealing with an overwhelming situation where you can't escape. So you split yourself into two roles.

It reminds me of this psychoanalyst, Bruno Bettelheim. Did you ever hear of Bruno Bettelheim? So he was a prisoner in a Nazi concentration camp. But he was also a psychoanalyst. And his way of coping with the horror of the situation was to do a silent research study. So he was a prisoner in this

Nazi concentration camp, but at the same time he was observing everything day-to-day, making mental notes. He planned to write a paper, a research study about all this when he got out. And he did get out, and he did write a research study. It became an important contribution to Holocaust literature. And General Eisenhower read the paper and General Eisenhower was impressed. It actually came to the attention of General Eisenhower! So Eisenhower had his people read the paper to see what was going on in these Nazi concentration camps.

[Arguably, the seeming circumstantial reference to Eisenhower is psychologically important. I had worked at a large law firm founded by a nationally-prominent attorney, Robert S. Strauss, at one time U.S. Ambassador to Russia and Chairman of the Democratic National Committee: an individual with connections at the highest levels of government, a friend of Presidents of the United States. Throughout my employment I fantasized about coming to his attention. I was a low-level employee, a paralegal: one of about sixty paralegals. But I developed the unsupported belief (or paranoid fantasy) that my writings had, in fact, come to Strauss's attention and that he developed a special interest in me. The reference to "General Eisenhower" in this portion of the narrative seems related to my fantasies about Robert Strauss. I was "Bruno Bettelheim," a prisoner of a "Nazi concentration camp" (symbolic of the law firm where I worked) who came to the attention of "General Eisenhower, Supreme Allied Commander in World War II" (symbolic of Robert Strauss), who took an interest in me because of my writings. See dream interpretation at Appendix A to this letter.]

PATIENT: So it's the same thing all over again. A person is in a bad situation that he can't escape from, so he mentally absents himself from the situation, and he does this research study in his mind. He takes on the role of a research scientist. So there are actually two identities: the person who is in deep pain who is experiencing all these bad things, but then there is also this other personality that is kind of hovering over the

situation and just observing.

[According to Shengold, a strong split between the *observing ego* and the *experiencing ego* (a *vertical split*) is indicative of child abuse. Strong and pervasive splitting and isolative defenses are what "is found in those who have to ward off the overstimulation and rage that are the results of child abuse." Shengold, L. *Soul Murder: The Effects of Childhood Abuse and Deprivation*. Vertical ego splits should alert the therapist "to the possibility that the patient is one of those who have lived through too much."

An entity termed "dissociative depression" – which combines dissociative and depressive features – has been found to affect patients who did not experience severe child abuse, but grew up in "dysfunctional" families (like mine) which seemed to be "apparently normal," being characterized by insecure attachment patterns, affect dysregulation, or narrow and rigid thinking styles *without an overt history of severe childhood abuse*. In fact, in today's view, dysfunctional communication styles of families (like e. g., pseudomutuality, marital schism, schizophrenogenic mother, double bind) which were once proposed to be a factor in the psychogenesis of schizophrenia, are in fact descriptive of dissociative patients' families rather than of those suffering from schizophrenia. The author reports that dissociative depression does not respond to antidepressant medication. Sar, V. "Dissociative Depression: a Common Cause of Treatment Resistance."]

PATIENT: That's the way it was at that law firm where I worked, where I was a victim of job harassment. These people were driving me crazy every day, but at the same time I was observing and making mental notes. I committed everything I experienced at work to memory. And when they fired me I got a notepad and wrote out everything I observed and experienced over the previous three years and I analyzed all these things in my writing. I was really two different people. And that was my coping

mechanism.

And I think the same thing was going on in my family when I was a kid. Of course, you know, when you're three years old you don't know what a research study is or what a research scientist is. So I wasn't thinking of that as a three-year-old. But I think it must be that there were these precursor states of mind in me when I was a kid. And when I grew up, these early precursor mental states were transformed into the concrete idea of the research scientist.

And I think the same thing goes on here with you. I'm in this therapy situation that is bad for me. And I view this as bad for me. So I deal with the situation as if I'm doing a scientific research study. I think my letters are related to that. See dream interpretation at Appendix A to this letter. So there are really two identities here with you. There's the me that feels stuck here and in mental pain, then there's this other me who is fascinated by all this and thinks about the meaning of all this, and who writes letters trying to make sense of it all.

THERAPIST: You shouldn't be in a therapy situation that you feel is bad for you. That's not psychotherapy. You need to have a good relationship with a therapist. You need to be in a therapy situation that you are comfortable with. You shouldn't be doing therapy as a sociologist. Therapy isn't supposed to be a research study.

[The therapist also talked about how I focused on "existential issues" at this session. She seemed to imply that my focus in this session was not appropriate for a therapy dialogue. She seemed to trivialize my observations that, in point of fact, concerned substantial concerns of psychotherapeutic importance, namely, depression, dissociation, trauma, response to an abusive family environment, paranoid fantasies, and schizoid states. All of these important issues were lost on this therapist, an individual who is, oddly, a trauma therapist. The entire session, as I see it,

was a narrative about depression and trauma. It's as if the therapist's only take away from my clinical narrative was that I was doing therapy the wrong way because I talked about "existential issues" and I viewed my therapy relationship as aversive. But why is it *inappropriate* for a patient to view his therapy relationship as a derivative of his past relationships in a disturbed family environment – rather than seeing the patient's construction as a transference phenomenon to be analyzed? I asked the therapist that very question and she had no answer. She simply repeated: "You shouldn't do therapy as a research study."

Existential depression is recognized as a substantial mental health concern; indeed, existential depression is considered a trauma issue:

"When people undergo a great trauma or other unsettling event—they have lost a job or a loved one dies, for example—their understanding of themselves or of their place in the world often disintegrates, and they temporarily "fall apart," experiencing a type of depression referred to as existential depression. Their ordeal highlights for them the transient nature of life and the lack of control that we have over so many events, and it raises questions about the meaning of our lives and our behaviors. For other people, the experience of existential depression seemingly arises spontaneously; it stems from their own perception of life, their thoughts about the world and their place in it, as well as the meaning of their life. While not universal, the experience of existential depression can challenge an individual's very survival and represents both a great challenge and at the same time an opportunity—an opportunity to seize control over one's life and turn the experience into a positive life lesson—an experience leading to personality growth. . . .

It has been my experience that gifted and talented persons are more likely than those who are less gifted to experience spontaneous existential depression as an outgrowth of their mental and emotional abilities and interactions with others. People who are bright are usually more intense,

sensitive, and idealistic, and they can see the inconsistencies and absurdities in the values and behaviors of others. . . . This spontaneous existential depression is also, I believe, typically associated with the disintegration experiences referred to by Dabrowski. In Dabrowski's approach, individuals who 'fall apart' must find some way to 'put themselves back together again,' either by reintegrating at their previous state or demonstrating growth by reintegrating at a new and higher level of functioning. Sadly, sometimes the outcome of this process may lead to chronic breakdown and disintegration. Whether existential depression and its resulting disintegration become positive or whether they stay negative depends on many factors." Webb, J.T. "Existential Depression in Gifted Individuals."

"[E]xistential depressions deserve careful attention, since they can be precursors to suicide." See, Webb, J.T. "Existential Depression in Gifted Individuals." "[T]he very intelligent can be prone to existential depression and can hide their depression very well, a fact that very few people know." Kishore, S. "Breaking the Culture of Silence on Physician Suicide."

How can a trauma therapist dismiss as gratuitous "existential issues" a depressive state that is recognized as a precursor to suicide? One can only be astounded.

I have the distinct impression the therapist was thinking unconsciously, "You don't tell me things that will allow me to showcase my talents as a supportive therapist who relies on soothing the patient." The therapist fails to recognize that soothing behavior by a therapist is ineffective in the treatment of existential depression, dissociation, vertical splitting, the structural sequelae of abuse, and schizoid states in a patient with high-level character pathology. Cf. Caligor, E. *Handbook of Dynamic Psychotherapy for Higher Level Personality Pathology*.

I am reminded of the narcissistic mother who experiences shame in

reaction to the infant who rejects her breast: "When you reject my breast you don't allow me to showcase my idealized identity as the all-giving and bountiful breast: the perfect mother." Compare: "When you talk about dissociation, schizoid states, and vertical splitting, you don't allow me to showcase my idealized identity as a supportive therapist who relies on soothing and symbiotic merger as therapeutic modalities."]

[At the conclusion of the session, as the therapist and I walked out the door of her office, she said to me: "Now you can go home and write all about how incompetent I am." The therapist exposed her overriding concern; she felt that my writings had marred her idealized self-image. I suspect that, in her mind, I was failing to participate in the therapist's narcissistic transference enactment (that requires that I regress to a state of symbiotic merger with her) and that, as a consequence, she experienced shame and envy in relation to me.

APPENDIX A – DREAM INTERPRETATION

Dream of the Botanical Monograph

Prefatory Comments:

Arnold Zweig (10 November 1887 – 26 November 1968) was a German writer and anti-war and antifascist activist. Zweig had written a book about antisemitism titled *Caliban* which he dedicated to Freud. Arnold Zweig was an associate of Freud's.

Stefan Zweig was a writer who collaborated with the composer Richard Strauss on the opera, *Die Schweigsame Frau* (*The Silent Woman*). Perhaps Strauss's most famous opera is *Der Rosenkavalier* which features a *silver rose* (*a token of love*) — the opera takes place in Vienna. Because Zweig was a Jew, the opera was banned by the Nazis.

In January 1991 I was in a car accident and suffered a fractured wrist and head concussion that caused a 2-hour coma (*brain issue*); I was hospitalized at GW. The doctor was John White, M.D. It was the beginning of the Gulf War in the Middle East. At the firm where I worked (*Akin Gump Strauss*) someone sent me a *plant or flowers* — the sender was not identified. Later that year I was terminated by the firm under cloudy circumstances.

In January 1977 I worked at The Franklin Institute in Philadelphia. In about January 1977 I had given *two white roses* to a coworker named Sharon White at The Franklin Institute where I was employed, together with a poem I had written. At that time I worked in an office with Silba Cunningham-Dunlop (she once mentioned that she was born on April 23, "Shakespeare's birthday," she said). Her Jewish father (Paul Frischauer), a writer, lived in Vienna (the city of his birth) at that time and had emigrated to Brazil during World War II to escape the Nazis. Silba's father died four months later, in May 1977 of a *brain tumor* (astrocytoma — astoria?). He was a terminal cancer patient.

In the spring of 1983 I helped Silba move from her apartment. She had her belongings packed in boxes. One small cardboard box contained a collection of numerous books. They were books that had been authored by her father, who wrote historical novels, including *Beaumarchais: Adventurer in the Century of Women*. I was astounded at the collection — the prolificity of his work. I suppose I was envious of Silba's father. Cf. Palombo, S.R. "Day Residue and Screen Memory in Freud's Dream of the Botanical Monograph" (Freud's dream recapitulated a series of Freud's earlier conflicts concerning his father and the power of books).

The inauguration of Jimmy Carter took place on January 20, 1977. Carter was advised by Bob Strauss—the founder of the law firm where I worked years later, in January 1991.

In 1938 Freud wrote to Zweig from Vienna: “Everything is growing ever darker, more threatening, and the awareness of one’s own helplessness ever more importunate.” (I quoted this in my book, *Significant Moments*.) In 1977 Silba Cunningham-Dunlop and I worked on a *monograph* on the carcinogenic properties of ionizing and nonionizing radiation.

June 11 was the birthday of composer, Richard Strauss. That evening, June 11, 2017, I had the following dream:

I am in the living room of the house where I grew up. Although it is daytime, the room is dimly lit. (In fact the room was always dark; the living room had only one small window). Someone has left a floral arrangement on a table. They are deep red astorias. In fact, there is no such flower. Someone has left a note attached to the flowers. It says, “Dark forces have overtaken Vienna, but the forces of light will someday return. Farewell, my beloved Vienna.” The note is signed Arnold Zweig. I sense that the note refers to the Nazi takeover of Austria in March 1938. I have the sense that sad events are happening elsewhere, but that I am safe in the living room of the house.

Every student of Freud’s will be familiar with the following dream:

Freud’s Dream of the Botanical Monograph is a short and sweet little ditty that goes a little something like this:

I had written a monograph on a certain plant. The book lay before me and I was at the moment turning over a folded colored plate. Bound up in each copy there was a dried specimen of the plant, as though it had been taken from a herbarium.

Freud’s interpretation of this dream is complex, and he returns to it multiple times throughout *The Interpretation of Dreams*. The most important symbolic significance that he teases out of it relates to the meaning of the “certain plant” that he studies in the dream.

Because Freud “really had written something in the nature of a monograph on a plant,” the monograph in the dream reminds him of his work on the coca-plant. So, the “certain plant” in the dream becomes a symbol of Freud’s work on the medicinal properties of cocaine—as well as a symbol of his mixed feelings about that work.

Freud viewed his work on the coca-plant with both positive and negative associations: positive, because he prided himself on having made important contributions to anesthesiology; and negative, because his recommended use of cocaine as a painkiller led to the death of his friend and colleague Ernst Fleischl von Marxow. With this in mind, the symbolic significance of the “certain plant” in the dream doesn’t just relate to the coca-plant itself, but to a whole slew of Freud’s professional ambitions and anxieties as well.

The important fact for me about Freud and cocaine was that Freud had experimented on himself with the substance. The following associations come to mind:

ASSOCIATIONS TO THE *GIFT OF RED FLOWERS*:

Poison Ivy – The Red Rash

In the spring of 1965, when I was 11, the following events transpired. I had the idea that I wanted to be a world famous scientist. I wanted to win a Nobel Prize in medicine. My first recollection of the Nobel was in the fall of 1964 (age 10), months earlier. Martin Luther King, Jr. had won the Peace Prize and my mother was incensed: “So now a convict gets a Nobel Prize!” My mother had strong racist convictions.

I had the idea that I would infect myself with poison ivy, a flowering plant, and then find a cure for the resulting rash. I stripped off the leaves (a twig? The German word *Zweig* means twig) of a poison ivy plant and

rubbed them all over my face. I came down with a horrible rash and suffered terribly. When I went to school my sixth grade teacher (Olga Kaempfer), fearing that I had an infectious disease, sent me to see the school nurse (Rose Heckman). Mrs. Heckman said I had a poison ivy infection and told me to apply calamine lotion. Thus, my hopes of a brilliant future as a research scientist were dashed! I would be forced to find another road to world historical glory ! That road would turn out to involve my fantasies about my relationship with Bob Strauss at the law firm where I worked. I imagined in fantasy that my writings had come to Strauss's attention and that he developed a special interest in me; my paranoid fantasy about Strauss gratified my need to come to the attention of a powerful figure (just as the concentration camp prisoner, Bruno Bettelheim had come to General Eisenhower's attention through his writings).

Freud's dream of the botanical monograph related, in Freud's analysis, to his earlier work on cocaine, derived from the coca plant. Like me, Freud had experimented on himself with cocaine. Like me, Freud had a lifelong desire to win a Nobel Prize; he was nominated for 12 years, but the nominations ceased forever when the Nobel committee engaged an expert who said that Freud's work was of no proven scientific worth.

So my dream seems to relate to my narcissistic need for fame and my idea of experimenting on myself. These issues seem to be at play in my letter writing in which I record and analyze my therapeutic sessions – as if I were doing important scientific work.

There is an aspect of dissociation here, or ego splitting, in which I am both the patient suffering from a mental disorder as well as the scientific researcher investigating that very disorder. In my therapy sessions it is as if I have taken on the role of both the patient undergoing treatment as well as the psychoanalyst analyzing a patient.

Scarlet Fever

At age 3 I came down with scarlet fever. My mother had indulged my taste for spoiled milk that I drank from a baby bottle. Scarlet fever causes a deep red rash, comparable, I suppose, to a poison ivy rash. When my pediatrician (Joseph Bloom, M.D.) diagnosed scarlet fever, he attributed the infection to the spoiled milk I had been drinking. Dr. Bloom scolded my parents in my presence in my bedroom: "Why is a three-year-old still drinking from a baby bottle? A three-year-old should not be drinking from a baby bottle." I remember laying in my crib, mortified and severely embarrassed. My secret was out! On top of that I was forced to relinquish my bottle (which may have been a transitional object for me); I experienced the loss of the bottle as notably distressing.

Our house had to be quarantined by the Philadelphia Department of Health (scarlet fever = deep red astorias = Dr. *Bloom* = poison ivy rash). Dr. Bloom explained to my parents that he was required to report my scarlet fever to the Health Department because it was considered a serious public health concern. (One wonders whether there was a connection in my mind between Dr. Bloom ("flower") communicating with the Health Department and Freud writing to Zweig ("twig")). This was a major emotional event from my childhood; the illness, which was blamed on my mother, caused a lot of tumult centering on my mother's parenting and the embarrassment to my family caused by the Health Department quarantine. The Health Department posted a notice on the front door of our house – a kind of scarlet letter. "You may not enter this premises."

Undoubtedly, at age three, I could not have processed the tumult in the household concerning the "Philadelphia Health Department." At the very least, I suppose, these events might have contributed to my sense that I was impactful – that my private affairs (my oral gratifications and associated fantasies) could influence the wider environment. These events might have confirmed my sense of omnipotence and my conviction

in the power of my magical thinking: the notion that my mere thoughts or sensations could arouse a response by remote objects (such as the Health Department).

I see a parallel between, on the one hand, my childhood illness (scarlet fever) and my transitional object (the baby bottle) coming to the attention of the Governmental authorities (The Philadelphia Health Department) under traumatic circumstances at age 3 and, on the other hand, my adult fantasy that my writings (a creative transitional object) had come to the attention of Bob Strauss (a friend of Presidents) who thereafter took a special interest in me. There is a further parallel with my fantasy at age 12 that a poison ivy rash I had caused – or my fantasied cure of that rash – would bring me to the attention of important people (The Nobel Prize Committee) who would recognize me as a great scientific researcher.

Additional Thought:

At a previous session (June 6, 2018) I talked with the therapist about a neighbor of mine, a young doctor I admired, who was doing a residency in obstetrics and gynecology. I reported that I was drawn to the fact that the doctor's published medical research had come to the attention of important people in his field – a fact that resonated with my fantasy world:

So, anyway, this goes back 15 years to the year 2003. There was a new guy in my building. His name was Brad Dolinsky. I didn't know anything about him. But I was curious about him. He wore Army fatigues sometimes. Once he gave some cookies to the guy at the front desk. In my mind, I thought of him as "the cookie guy." He was somebody I would be interested in talking to. I asked the front desk manager who he was. She said, "That's Brad Dolinsky. He's a doctor. He's doing his residency at Walter Reed. He's very smart.

There are people high up in his field who have their eye on him."

I thought, “I knew it! I could tell there was something different about that guy.” So I researched the guy on the Internet. And I learned that there were several technical papers that he had co-authored – and he was still only a resident. This confirmed for me that I can read people.

Therapy Session: December 18, 2018

In every garment, I suppose I'm bound to feel the misery of earth's constricted life. I am too old for mere amusement and still too young to be without desire. What has the world to offer me? You must renounce! Renounce your wishes! This is the never-ending litany which every man hears ringing in his ears, which every hour hoarsely tolls throughout the livelong day.

—Johann Wolfgang von Goethe, *Faust*.

The past was erased, the erasure was forgotten, the lie became truth. If the Party could thrust its hand into the past and say of this or that event, IT NEVER HAPPENED—that, surely, was more terrifying than mere torture and death?

—George Orwell, *1984*.

The two aims of the Party are to conquer the whole surface of the earth and to extinguish once and for all the possibility of independent thought. There are therefore two great problems which the Party is concerned to solve.

—George Orwell, *1984*.

I shall always be a flower girl to Professor Higgins, because he always treats me as a flower girl, and always will; but I know I can be a lady to you, because you always treat me as a lady, and always will.

— George Bernard Shaw, *Pygmalion*

PATIENT: So, you know, something has been preying on my mind the last week. I keep wondering what it is we are doing here. What is it that you are trying to accomplish with me? I don't know. I just wonder about that.

[The therapist didn't respond to my concerns.]

I kept thinking about my idea that I was an intruder in my family. I was kind of dismayed about your reaction to that. You seemed to challenge

that idea. I don't know, maybe you weren't challenging that idea. But I wonder, were you challenging that idea?

THERAPIST: Did you think I was challenging that idea?

PATIENT: I don't know. That's why I'm asking. But I thought that perhaps you were challenging my idea that I was an intruder in my family, that I had destroyed my parents' paradise—something we talked about—that I was an outsider or scapegoat in my family.

THERAPIST: I don't think I was challenging that idea.

PATIENT: Well, I raised the issue three times in past sessions. And each time you said things that made me think you were challenging that idea. I remember the first time I mentioned that I had destroyed my parents' paradise. And you seemed to dispute that.

[At the session on August 21, 2018 I said that I had formed the tentative idea that perhaps my parents had viewed the six-year period before I was born as idyllic, as a kind of paradise. It was the first seven years of their marriage, and after their first year of marriage they had a daughter, my sister, who was idealized by them.

I recorded that the therapist had responded in the following way to my comments at that session: "*The therapist pursued the issue of factual truth. The therapist said, "Maybe it wasn't idyllic for your parents. Maybe that's your misinterpretation (of the facts). Maybe there were problems even before you were born."* Notice how the therapist is taking subjective, or psychic, truth and measuring it by objective standards and saying, in effect, "Maybe you are factually wrong. Maybe your parents were not so happy before you were born. Maybe that is simply your (factually distorted) narrative. Let's reality check your belief." Yes, that is my narrative and my narrative has both factual and psychic components. The

therapist seems mired in the factual and the real, as if she sees herself as a fact-checker for The Washington Post. If our narratives were all factually accurate, we would all have the same narrative, and we would all be alike; there would be no individuality. But note well: only in cults is the lack of individuality a virtue. It is our personal myths, composed of the symbolic and the imaginary, that make us individuals. As Woody Allen has said, “All people know the same truth. Our lives consist of how we choose to distort it.”]

PATIENT: Then, the second time I mentioned that my parents viewed me as an intruder, you said, “Did we actually agree that that was the case?” [In this instance the therapist appeared to want to extinguish the possibility of independent thought. Similarly, on another occasion, she asked: “Are we on the same page?”]

THERAPIST: I didn’t say that.

[I have learned to ignore my therapist when she denies having said something that I recall her having said. I see the therapist’s denials as instances of gaslighting: her attempt to erase the past. Gaslighting is a form of projective identification where one individual attempts to deny facts, events, or what one did or did not say. Gaslighting is not an uncommon practice among psychotherapists. Dorpat, T.L., *Gaslighting, The Double Whammy, Interrogation And Other Methods Of Covert Control In Psychotherapy And Analysis*.]

PATIENT: Then, the third time I said that I thought I was an intruder in my family you said, “Did anybody ever actually tell you that?”

THERAPIST: That’s not something I would say. I recognize that it’s your sense of things that you were an intruder.

[I have a firm recollection of the therapist having said “Did somebody ever actually tell you that?” because I remember responding, “Well, my

niece said to me on one occasion, ‘My mother says she wishes you were never born.’ The therapist then replied: “Why did your sister say that?” And I replied: “Jealousy. One psychiatrist said, ‘Your sister was the little princess for six years. Then you came along. You toppled her from her pedestal.’” My inference is that the therapist’s other patients won’t question the therapist’s many contradictions, false denials, and questionable statements because they have regressed to a state of infantile symbiosis with her, a state in which they assume a referential posture or an unquestioning worshipful attitude toward her. These patients have lost their rationality. In my relationship with the therapist I remain rational and critical of the therapist’s limitations. By analogy, committed Communists in the Soviet Union were blind to the flaws in the Party’s pronouncements. Cynical citizens, on the other hand, were left bemused and uncomprehending by the Party’s utterances.]

PATIENT: Yes, it’s my sense of things that I was an intruder. But there is more than that. If you look at all the things I’ve said about my family you can see that, in fact, I was seen as an intruder in my family. It’s not just my sense of things. I mean, we talked about the issue of intergenerational transmission of trauma; typically, in dysfunctional families who scapegoat a child you will find a history of intergenerational transmission. We talked about the fact that my parents argued all the time: that there was a lot of parental discord, which is consistent with scapegoating. We talked about the issue of parental favoritism: my sense that my parents favored my sister over me. Like, for example, I always had the feeling that my parents criticized me all the time and that they almost never criticized my sister.

But then the really crucial thing is my attachment style. I have a dismissive avoidant attachment style. I am cut off from people but I don’t feel lonely. I seem to dismiss the value of relationships. They say that a dismissive avoidant attachment style is generally caused by a rejecting mother. So, it’s kind of like my attachment style speaks for itself. My

having had a rejecting mother seems to fit in with the idea that, in fact, I was an intruder in my family. And you know what? I'm thinking something interesting. A person who is securely attached would never say, he would never have the feeling, that he was an intruder in his family. He just wouldn't say that; he wouldn't feel that. A securely attached person would have the idea that he was loved by his parents. So the mere fact that I would say that I viewed myself as an intruder is kind of self-proving. Only a person who was in fact treated like an intruder would even say that he had the idea that his parents viewed him as an intruder. You didn't seem to see that. It's all recorded in the person's internal working model, according to attachment theorists. If a person was an intruder in his family, that will be recorded in his internal working model – it will be recorded in his attachment style. Certain types of parental interactions will give rise to certain attachment styles in the child. So the idea of whether my sense of my family is correct or not is something that can be revealed if you simply look at my internal working model. According to attachment theory, the nature of my adult relationships will tell you what my early relationships were. It's not even something that you need to speculate about. It's all recorded in the internal working model. It's all recorded in my attachment style.

But there's something else I want to mention. You look at the things I talk about here, and you seem to assume that I've always thought this way. That, for example, if I say that I felt that I was an intruder, then I felt that way as a child. And you seem to assume that you need to challenge that idea – that negative thought. But I didn't feel that way as a child. I didn't see myself as an intruder when I was a kid. Well, maybe at some level I felt like an intruder, but that was never my conscious perception. Let me tell you something that highlights what I am talking about. When I was 24 years old I was seeing a psychiatrist, and he said, "You were abused. You had to have been abused. Only people who were abused have the personality problems you have." And you know what? I was incredulous. I said to him, "I was never abused." That never entered my

mind. I never thought of myself as an abused person. But as the years went on and I started thinking about my family, I arrived at new insights about my family and my place in the family. I began to see how I was an intruder or scapegoat in my family. So that represents a new way of thinking for me that only emerged in adulthood. I never had those thoughts as a child. The thing is, when a patient talks about his childhood does his description relate to longstanding distortions in his thinking – or does it actually reflect emotional growth and growing insight and his ability to deal with painful truths that he could have never have faced when he was a child? You don't know that when I, or anyone, talks about his childhood. You seem to assume that if I say something negative about my childhood or people in my family these things are distortions— and you feel a need to challenge my "distorted thinking." But what about the extent to which my ideas reflect emotional growth and insight and the breakdown of childhood idealization? You don't know that and you make assumptions and challenge what I am saying, when, in fact, what I am saying may represent mental health and not mental weakness.

You know, I saw an interesting YouTube of John Bowlby. He's the father of attachment theory. It's a five-minute video and he was giving a talk and he said there are patients who are convinced that their mothers loved them, but that's a false belief. That belief is simply a product of idealization. In fact, their mothers never loved them. And he said, you need to get the patient to the point of understanding that his mother never loved him—that he was never loved. Bowlby said, "the patient will be better off in the long run knowing the truth of his mother's feelings for him."

Bowlby said: "So there is a reason why I think it's – the greatest reason to assist a patient *discover their own past* and also, of course, to realize, to recognize, how it comes about how they cannot initially come to, can't do it, or don't want to do it. Either it's too painful – no one wants to think

that our mother never wanted them, and always really rejected them, it's a very painful, very, very painful situation for anyone to find themselves in. Yet if it's true, it's true, and they are going to be better off in the future if they recognize that that is what did happen." John Bowlby on Attachment and Loss, videotaped presentation, 1984.

[Bowlby saw important therapeutic value in helping the patient to see that the parent's lies did not remain the patient's truth. Bowlby's technique contrasts with the therapist's Pollyanna-like strategy of preserving the parent's idealized self-image. At the first session when I told the therapist that my mother was negligent, she replied: "I wouldn't say she was negligent." How would she know that at the first session? If I had a negligent mother, wouldn't I be better off in the future if I recognized that that was the case? When I offered speculation that my maternal grandfather might have been exploitative, she said, "I wouldn't say he was exploitative; maybe he was an optimist."]

THERAPIST: And how would you feel if you had the idea that your mother never loved you?

PATIENT: I guess that would be kind of sad. But, you know, I don't really know. I guess it would be sad.

[The gist of my opening comments centered on my sense of myself as an intruder in my family and facts tending to support my lived experience as an intruder. My comments alluded to parental rejection, scapegoating, targeted criticism, and parental favoritism: forms of emotional abuse that are associated with the development of a dismissive avoidant attachment style. See, e.g., Muller, R.T. "Trauma and Dismissing (Avoidant) Attachment: Intervention Strategies in Individual Psychotherapy." These are trauma issues that need to be addressed by the therapist, and not denied by misdirection. The therapist focused on my reference to Bowlby

to promote her need to depict me as struggling only with proximity-seeking, that is my thwarted need for mother's love, rather than interfamily abuse. "Individuals who are dismissing of attachment put considerable psychological effort into closing off discussion of threatening issues. Unless challenged [by the therapist], such issues will likely remain closed off." See Muller. In my opening comments I approached threatening issues of interfamily abuse that needed to be pursued by the therapist. Instead, the therapist ignored these issues of abuse and directed her attention to proximity-seeking with mother. "The challenge facing the therapist is to make active attempts to turn his or her attention toward *trauma-related material*; to listen for it, notice it, ask about it, and facilitate rather than avoid such painful topics. If not, the risk is that of replicating the rejecting response of the parent who reacts to the child's abuse revelations by discounting or minimizing their importance." See Muller.

[I had the impression that the therapist seemed dismayed that I cut off my discussion of my feelings about what it would mean to me if my mother didn't love me. I viewed the therapist's question as off point, as not relating to what I had on my mind, as if she were pursing her agenda – which seems to focus, in her mind, on my need for mother's love – instead of thinking about what was unconsciously pressing on my mind that afternoon. This clinical exchange is emblematic of my conflicts with the therapist. It is my belief that she picks and chooses fragments of my narrative to comment on, based on her projective needs, without regard to what is pressing on my mind unconsciously. She consistently does not allow meaning to emerge from the context of my associations. She seems oblivious to the importance of context and the meaning that emerges from an assessment of the associations in my narrative.

When the therapist asked: "And how would you feel if you had the idea that your mother never loved you?" did she want me to talk about how

sad it would be not to be loved by one's mother? Was the therapist projecting a need for me to talk about the *state of wanting* something that was being withheld from me, namely my mother's love? Was the therapist unconsciously asking, "When you were an infant did you not want desperately to suck on your mother's breast? And did you not have feelings of envy for your mother's breast when your mother had milk that you wanted, but that you felt she withheld from you?" When I shared facts with the therapist about John Bowlby and attachment theory that may have been outside her fund of knowledge, did the therapist experience envy of my possible superior knowledge that she then tried to discharge through projective identification, namely, by imputing breast envy to me ("How would you feel if you had the idea that your mother never loved you" – that is, how would you feel if your mother had something [love or milk] that you wanted?) and then directing me to talk about that breast envy? Did my evasive response ("I guess that would be kind of sad") really amount to my attempt to refuse her projective identification? I will return to these ideas later in this letter.

I recall an interaction from a previous session on May 29, 2018. I had pointed out facts about attachment theory to the therapist – the therapist fancies herself an attachment therapist – that were at odds with her knowledge base. I then talked at that session about an email exchange I had had with a leading attachment theorist, a university professor. The therapist later had an outburst: "You think you're smarter than everybody else." *Will the therapist typically respond with verbal aggression or projective identification of envy in instances where she feels I possess something that she lacks?*

A digression. In the letter about the session on August 21, 2018, I imagined a fictional psychoanalyst commenting on my belief that I was an intruder in my family, an intruder who had destroyed my parents' paradise, that is, the six-year period in my parents' marriage before I was born. In that letter I had the fictional psychoanalyst say: "*I sense possible*

envy and unconscious feelings of triumph in your report that you destroyed your parents' paradise. I suspect that at some level you relished the idea of destroying your parents' 'beautiful world' because it was denied to you. You know there is a psychological theory that the infant both loves and envies the mother's breast: that at some level the infant wants to destroy the mother's breast – precisely because it is good – at those moments the infant feels that the mother has withheld the breast from him. Your family's beautiful world, their Paradise as you call it, was denied to you and you envied it; you wanted to destroy it. I'd like to offer a reconstruction that ties together your creativity and your destructive impulses. It may be that a regular feature of your mental life is that when you envy something and cannot merge with it, you destroy it in fantasy, then recreate an image of that envied object in your mind. What I am saying is that you envied your parents' paradise, you could not have it, you proceeded to destroy it in fantasy, and you resurrected an idealized image of it in your inner world. I suspect that we can find residues of former envied objects in your idealized world, your inner Garden of Eden, your own private paradise, that you retreat to."

The above speculations find some support in Melanie Klein's view that idealization can be a defense against envy. Klein and others suggest that the idealizing transference in therapy is in part a defense against the person's envy of the therapist, as well as being an indication that envy was an overwhelming experience for the person as an infant. She suggests that before the person can consciously accept envy of the therapist, the idealizing transference needs to run its course without interruption or interpretation, and the person needs to become stronger through gradual increments of frustration in the therapy.

Is it noteworthy in this regard that my therapy relationship with Stanley R. Palombo, M.D. was marked by my intense idealization of him coupled with painful feelings about him centering on my sense that he was insensitive to my feelings of victimization – thereby thwarting my hunger for empathic understanding?

What I am proposing here psychoanalytically is that (1) my therapist's

response to me at this session – namely, her possible projective identification of envy onto me by having me talk about my feelings about my mother withholding her love from me (“And how would you feel if you had the idea that your mother never loved you?”) – and (2) my possible psychological response in childhood to my sense that my family had a paradise that was denied to me, which involved my destroying that “paradise” in fantasy and proceeding to internalize an idealized image of that paradise in fantasy – represent two distinct vicissitudes of envy and destructive impulses. I propose that an elaboration of these issues, these two vicissitudes of envy and destructive impulses as between the therapist and me, which amounts to a transference/countertransference enactment, would say a lot about the therapist’s and my distinct levels of ego development as well as the nature of my psychological relationship with the therapist and, further, about my difficult relationships in the wider world.

Is it possible that my putative tendency to idealize envied objects and introject them is rooted in an array of transformations of instinctual orality, greed, and envy of unusual intensity?

Introduction is a psychoanalytic concept referring to the psychic process whereby objects from the external world – prototypically parental objects – are taken into the ego, internalized. Introduction is a phantasmatic process – it is not real objects that are taken in – that finds its bodily analogue in orality, ingestion. Truscott, R. “Introduction.” Freud stated that introduction “is a kind of a regression to the mechanism of the oral phase.” See, “The Ego and the Id.” Susan Isaacs assumed that behind every phantasy of introduction there is an earlier one of concrete incorporation. Satisfaction is experienced as containing a need-fulfilling object; hunger as a persecution. See, Segal, H., *Dream, Phantasy and Art*.

First, my tendency to intense idealization of external objects might be seen as an expression of a transformation of oral greed. Klein posited

that under circumstances of intense greed only hallucinatory wish-fulfillment brings satisfaction, since the conjured breast is inexhaustible. A pathway from greed to idealization is thus opened up; restless search for “all-good” objects (e.g., a perfect friend or an exquisitely attuned therapist) then becomes a lifelong pattern.

Second, might not intense orality and greed be seen as underlying other of my character traits, such as, my self-abnegation or instinctual renunciation, that is, my asceticism and pathological self-sufficiency?

Klein argued for how a strict super-ego may be given its force and its imprint from early infantile oral impulses, producing a biting, devouring and cutting policing of adherence to an ego-ideal. Truscott, R. “*Introjection*.” Under the influence of a harsh superego, greed is repressed and denied, *leading to false self-reliance, stifling of love, and turning away from dependence upon others*. Akhtar, S., *Greed: Developmental, Cultural, and Clinical Realms*. A not infrequent accompaniment to repressed greed is pretended contempt for money in real life and “*moral narcissism*,” that is, yearning to be pure, free of attachment, and above ordinary human needs. Disenchantment with food to the extent of developing anorexia nervosa is often the consequence of such narcissism and repressed greed. Akhtar, S. *Sources of Suffering: Fear, Greed, Guilt, Deception, Betrayal, and Revenge*.

Be that as it may.

It is clear to me that the therapist is concerned only with the nurturing aspects of the mother-child relationship, which, in her view, is an expression of her interest in attachment theory. But the therapist has no interest in the core tenets of attachment theory, such as the internal working model both conscious and unconscious; her interest in attachment theory is simply based on a distorted view of attachment theory that justifies what is essentially her preoccupation with infantile

symbiosis. Her concerns center fundamentally on the patient's desire for and union with the Good Mother, while she ignores the pathological outcomes of an infant's struggles with the Bad Mother.

As I have written elsewhere, I strongly suspect that for this therapist the absent Good Mother is indistinguishable from the present Bad Mother (the frustrating, aggressive, or seductive mother). This became plainly apparent earlier in this session. When I told the therapist that my attachment insecurity – in the form of my adult dismissive avoidant attachment style – would have been the result of my relationship with a *rejecting mother* (the “Bad Mother”), she was unable to process that and had, at three previous sessions, failed to see that my perception of myself as an intruder in my family was intimately bound up with my lived experience with an inadequate or rejecting mother. In effect, the therapist equates *maternal absence* with *maternal empathic failure* so that in the end there can only be one outcome: an infant whose proximity-seeking with mother is thwarted, an infant who is denied mother's love. But that's clearly not true. An infant's struggles with a lack of maternal empathy are based on faulty *interactions* with mother that result in pathological adaptations or psychic structures specific to those faulty interactions – and not maternal absence. An infant that develops faulty psychic structures is not necessarily struggling only with a lack of maternal love.

I find it telling in this regard that the therapist seems incapable of processing issues of adult narcissism; she is unable to distinguish (1) the painful feelings of loneliness that an isolated patient might feel whose proximity-seeking with another is thwarted from (2) the specific narcissistic pain experienced by an isolated patient whose extravagant pathological need for the perfect (idealized) friend is thwarted, as if all isolated patients are simply lonely. They are not. Some such patients struggle, like me, with the specific mental pain associated with the frustration of their narcissistic needs. That's not loneliness.

I perceive the therapist as deluded, deceptive and self-interested: her therapeutic technique is not rooted in the genuine needs and psychological concerns of a patient at a high level of ego differentiation who also experienced an emotionally abusive family environment, but in her unconscious need to work through her own attachment insecurity with her mother.]

PATIENT: You know I'm fascinated by Trump. The corruption of the Trump Administration. I'm following all the news about that. I think my family was corrupt. It was emotionally corrupt. These were emotionally corrupt people. There was all kinds of artificiality about my family. They seemed to think they were just a normal family, but it wasn't a normal family. They were all pursuing their own agendas. It was a dysfunctional family. (They were deluded, deceptive and self-interested people.) [Aren't my references to corruption an expression of my *moral narcissism*, that is, my yearning to be pure and above ordinary human needs: a trait that might be rooted in repressed greed? The moral narcissist dreads living with the corrupted self and experiences contempt for the perceived corruption of others. Moral narcissists strive to live up to their ego ideal, as Freud would have it, rather than lower the ideal; they are individuals who feel compelled to "commit the truth." Thus, my references to the corruption of the Trump Administration and the perceived corruption of my family might represent another transformation of repressed greed.] [Adults with a dismissive attachment often describe their family of origin experiences with parents as well as their own dynamics as consistently unresponsive; positive view of self, negative view of others; compulsive self-sufficiency; parents were rejecting, distant, withdrawn away a lot; *false claim to normality*; independent, invulnerable and deny need for relationships; "emotional distancing"; detached from feelings; consequences of negative behavior go unchecked; and "uncomfortable being too close to others". They downplay the importance of intimate relationships. Rovers, M. "Family of Origin Theory, Attachment Theory and the Genogram: Developing a New Assessment Paradigm for Couple

Therapy."

Note how my observation "They seemed to think they were just a normal family, but it wasn't a normal family" fits squarely with Rover's statement that dismissive avoidant individuals describe their families as having a "false claim to normality." My comments about my family fall squarely within the interest of attachment work, yet the therapist totally ignored my comments about my family and the possible etiologic role my family had on the development of my dismissive avoidant attachment style, and instead interpreted my comments about my family at a later point in the session as a projective expression of my concerns for "generativity." Again, the therapist's claim to an interest in and knowledge about attachment work is questionable.]

PATIENT: We were talking about my aunt last week, my mother's older sister. She seemed to have the idea that she was the hero of the family, the caretaker. That she was concerned for us and wanted to make our life better. I bought into that idea when I was a kid and I idealized her. But then, beginning when I was a teenager, I began to have a different view of her. As an adult I have come to see just how much she resembled the Communist Party of the Soviet Union. It's remarkable, really. The Communist Party promoted a view of itself as the benefactor of the Russian people, providing all kinds of things, like low-cost housing, free education, free medical care and other things. That they were acting purely out of altruism and a humanistic concern for the population. But that was all an illusion. That was an idealized self-image the Party promoted to justify their real ends which were power and a political agenda based on defenses against envy (all were propertyless; no one coveted his neighbor's possessions). It was a brutal regime that was only concerned with the interests of the Party itself, not with the people.

I am intrigued with the idea that that is something that went on at a political, social level but that we can see that in individual psychology.

People who present themselves as altruistic, caring people. But they are not altruistic and caring. They are driven by envy and power and the idealized self-image they promote is simply a way of pulling a fast one over on their victims. Like my aunt presented herself as altruistic. It was funny how she would talk about property taxes. You know, property taxes go to paying for education. It goes to kids. But she always complained about that. "Why should we have to pay property tax? We have no children. I don't think we should have to pay property tax." Or social welfare programs. She used to rail against social welfare programs. Like food stamps. I think that was all based on envy. When she was a kid, she lived in dire poverty in the 1920s, before social welfare programs. She didn't like the fact that people today get help from the government that wasn't available when she was a kid. Well, that's pure envy.

[The transference aspects of my narrative were lost on the therapist. When I talked about my aunt as psychologically corrupt was I not symbolically talking about my feelings about her? She ignored the context. Did I not open the session by complaining about her? "So, you know, something has been preying on my mind the last week. I keep wondering what it is we are doing here. What is it that you are trying to accomplish with me? I don't know. I just wonder about that." A cynical Soviet citizen might well ask of the Party: "What are you trying to accomplish? You provide socialized benefits as if you are concerned for our welfare, but you also exploit us in a way that suggests that you are simply power hungry and out to satisfy only the needs of the Party?" Am I not saying about the therapist: "You claim to be concerned about me, but you seem self-interested and intrusive. I feel your work is based on forcing your values on me and discharging your own anxieties relating to fears of rejection and need for belonging and acceptance." Did I not previously write about my perception of the therapist as a cult leader intent on subjugating her patients and denying their identity and individuality? The therapist failed to see the connection between, on the one hand, my sense of her as a cult-leader, and, on the other, my implicit

view that my aunt was a cult-leader (“the hero of the family”) and that my family was a cult.]

PATIENT: I keep thinking about something in connection with my aunt. It fascinates me. You know, she had this obsession with gardening and trees. She lived in a house in the suburbs that was on a lot of ground (0.34 acres). They had a huge lawn and they spent thousands of dollars on lawn treatments to have the perfect lawn. And this is really weird. She had all different kinds of trees. They were her children really. She had no children and her trees and her flowers and lawn were her children. She used to say to my mother, “If we ever move, we plan to have our favorite trees dug up and replanted at our new house.” Who talks like that? Who has favorite trees? I have a sense that it was all about envy. She used to talk about how when they moved into their house – it was a new development – most of her neighbors were young couples just starting out. They had young kids. And she had no kids. And I think she wanted her trees and her lawn to be special, as if she were trying to arouse envy in her neighbors – wanting to show off her beautiful trees and lawn – to discharge her own envy of her neighbors having kids.

But then there’s something related. They had an interest in dogs and dog breeding. They used to go to dog shows. They once brought me and my sister along to a dog show. They seemed preoccupied with different breeds of dogs – and breeding the perfect dog – the same way they seemed preoccupied with the lawn and their trees.

And the issue is that I think that the psychological thing that drove her obsession with dog breeding and plant breeding was the driving force in her relationship with me and my sister. I think she wanted to breed perfect children. She was looking for perfection and she wanted to be able to say that she had a hand in making us perfect.

THERAPIST: Did your aunt ever say that she wanted children?

[Compare the therapist's previous question: "Did anybody ever actually tell you that you were an intruder?" The therapist showed her concern for factual correctness and her reluctance or inability to think about the meanings that underlie the overt words and actions of other people. She tends to focus exclusively on the literal. I have a sense that the therapist is a concrete thinker; that she is unable to see symbolic meaning. She is only capable of talking about what "is"—she cannot cognitively process an "as if" state. In the October 2, 2018 Therapy Session I wrote: "From a psychodynamic perspective, we would say that the more-desymbolized [literal-minded] person has an impaired capacity for personal reflection and an impaired ability to think about the meanings that underlie the overt words and actions of other people." Was the therapist even able to see the symbolic meaning of my aunt's interest in tree breeding and dog breeding?

I wonder about the therapist's capacity to mentalize. Mentalization, according to Fonagy and Target, offers the child an opportunity to find meaning in people's actions, a clear demarcation between inner and external reality, the capacity to manipulate mental representations defensively, a good level of intersubjective contact with others, and so on. Mentalization places the child more in touch with his own and other's feelings, beliefs, and desires; this reinforces attunement with other people. In its earliest years, the child experiences ideas as (literal) *replicas* of external reality. Ideas are not recognized as such, as there are no proper representations of oneself and others. The internal world is expected to function under the rules of physical causality and to correspond to external reality. Only later does the child develop a reflective self, capable of *constructing representations* about its own and other's actions, distinguished from a pre-reflective self, incapable of taking an observing and knowing stance with respect to itself. The reflective, or mentalizing, self develops from the exchanges with another mind in an inter-subjective framework.

At times I have the sense that the therapist has the limited mentalizing capacity of a very young child; she seems incapable of recognizing that individuals can have the ability to form reasonable inferences about others' mental states – that they don't need to be expressly told in so many words about someone's mental state to infer things about a person's mental state. Lagos, C.M. "The Theory of Thinking and the Capacity to Mentalize: A Comparison of Fonagy's and Bion's Models." Is there some relationship between the therapist's putative impaired mentalizing ability and her need to deny my subjectivity, which is rooted in my ability to construct subjective representations of others? Does the therapist have the ability to see me "as a separate being with a mind of [my] own, capable potentially of reading [the therapist's] mind as well as [my] own"? Wallin, D.J. *Attachment in Psychotherapy.*]

PATIENT: I don't remember my aunt saying she wanted children. But I'm guessing that she did. She seemed to see my sister and me as her own children. She had a real boundary thing. She had no sense at all that her behavior posed a boundary issue: her constant criticism of me, her constantly correcting me, her trying to perfect me. The way she interacted with me she seemed to assume the role of a parent. It was disturbing to me. (My sense is that it was "as if" she saw me as one of her flowers that she could perfect by pruning or a dog she could train.)

THERAPIST: Tell me about your own need for generativity.

[Again, I was approaching disturbing trauma material—my experiences in a dysfunctional family that were bound up with the development of my dismissive avoidant attachment style—and the therapist took a detour by imputing a projective meaning ("generativity") to my comments that imputed to my aunt a benevolent concern with having children. Instead of focusing on my implied anxiety about my having been treated in childhood like a dog-in-need-of-training or a flower-in-need-of-pruning, the

therapist projected onto me a sanguine desire to have children. The therapist treated my comments about breeding perfection as if they were simply a projection of my agreeable desire for children, rather than a discussion of my disturbed and distressing relationships (attachments) in a dysfunctional family. It is recognized that therapy work with dismissive avoidant patients needs to involve helping the patient achieve insight and perspective on his developmental trajectory within a particular family context. Connors, M.E. "The Renunciation of Love: Dismissive Attachment and its Treatment." Note also, the therapist's act of draining my aunt's narcissistic preoccupations—her need to breed perfection—of any pathological narcissism. As I stated previously: "I find it telling . . . that the therapist seems incapable of processing issues of adult narcissism."

First, a technical issue. Projection is an ego defense rooted in psychoanalytic theory. In analysis, a defense mechanism is an unconscious psychological mechanism that reduces anxiety arising from unacceptable or potentially harmful impulses. The acceptance of defense mechanisms as a concept assumes the existence of a dynamic unconscious that directs conscious thought and behavior. But the notion of a dynamic unconscious is foreign to attachment theory. In fact, attachment theorists disdain the concept of defense mechanisms altogether. They have developed their own equivalent concepts that describe the individual's attempts to ward off unacknowledged attachment anxieties—not unconscious impulses. In place of the term projection, attachment theorists talk about "cognitive disconnection"; "deactivation" replaces denial; and "segregated systems" replaces identification. See, Rivas, E.M., "A Comparison of Attachment-Related Defenses and Ego Defense Mechanisms." Psychoanalytic defense mechanisms have as much conceptual relevance to attachment work as a steak knife has to brain surgery. What does it say about a therapist who claims to be an attachment therapist that she continually falls back on the concepts of

psychoanalysis—a therapeutic technique about which the therapist has in fact voiced contempt?

When I talked about my aunt wanting to breed perfection—in trees, dogs, and children—I was specifically alluding to her narcissism and not her concern with generativity, *per se*. I had in mind her desire to bring into existence idealized creations that would reflect back positively on her and burnish her idealized self-image. I am reminded somewhat of the myth of Pygmalion, a sculptor who fell in love with a perfect statue of a woman he had carved. It is uncannily striking that my aunt once talked about her love of the Broadway musical, *My Fair Lady*. She had a recording of the show and once mentioned that she would listen to the recording again and again while she was doing house chores. *My Fair Lady* is based on the Pygmalion myth.

I also think of the utopian implications of breeding perfection, which come into play in both cults and totalitarian states. The Third Reich as well as the Soviet Union sought to create the perfect society. As I mentioned previously, it is well to keep in mind that the reality of the Soviet Union was that it was a repressive state whose well-crafted idealized self-image camouflaged its true aims: power and defenses against envy (in the Communist state no one owns property, and thus no one will covet another's property).

My imagery points to my sense of my aunt as a traumatizing narcissist. The psychoanalyst Daniel Shaw describes the relational system of what he terms the “traumatizing narcissist” as a system of subjugation—the objectification of one person in a relationship as the means of enforcing the dominance of the subjectivity of the other. Shaw, D. *Traumatic Narcissism: Relational Systems of Subjugation*. Shaw demonstrates how narcissism can best be understood not merely as character, but as the result of the specific trauma of subjugation, in which one person is required to become the object for a significant other who demands

hegemonic subjectivity. The subjugated party is denied independent thought. My aunt in her interactions with my family symbolically assumed the role of a colonial power, using her psychological fusion with my mother (as well as my father's dependency) to gain influence over my family, just as a colonial power takes control of a native population. Indeed, Shaw has written: "Bach has [stated] that 'the overinflated narcissist can experience himself as cohesive and alive only at the expense of devitalizing his objects.' To achieve this goal of devitalization, the traumatizing narcissist virtually *colonizes* others, using them as hosts, as it were, in whom to project and control his unwanted and disavowed affects and self-states connected to dependency—especially the shameful sense of neediness [*a state of wanting*] and inferiority (emphasis added)." Shaw, D. "The Relational System of the Traumatizing Narcissist."

The therapist ignored the significant trauma issues implied in my narrative that centered on my tortured past, my tortured childhood, "as if" to erase that past. It was "as if" she had thrust her hand into the past and said, "It never happened." She then proceeded to redirect the discussion in an anodyne fashion: "Tell me about your own [*present*] need for generativity." But what did my narrative say about my *past* disturbed relationships (attachments) in my family as well as my present psychological struggles as a person who experienced an afflicted past?]

PATIENT: Oh, yes. Generativity is very important for me. For me, my books and my writings are my children. I love them and dote on them like children. I go over what I have written again and again to perfect every phrase. I'm constantly editing what I write like a mother doting on her children. I want my writing to be perfect. My books are my legacy. I feel that they will live on after me. People who have children look to their children as their legacy. For me, it's my books. They will live on after me. It's important to me to create, to bring into existence things that are meaningful to me and I do that through my writing.

[Let us look more closely at the therapist's comment, "Tell me about your own need for generativity." The therapist is asking about my desire to have children; she is talking once again about my *state of wanting*. This parallels the therapist's earlier statement that focused on my *state of wanting*: "And how would you feel if you had the idea that your mother never loved you?" The therapist's question about generativity concerned my *wanting* to have children; her question about my mother concerned my *wanting* my mother's love.

It is my interpretation that both of the therapist's statements constituted a projective identification of the therapist's envy onto me. The therapist at this session was concerned with abreacting her unconscious sense of envy of me (*a state of wanting*) by prompting me to talk about my *state of wanting* in two different contexts. When I responded with a discussion of my creativity—my writing books—I was refusing to accept the therapist's projective identification of envy. The wider implications of this transference/countertransference enactment need to be explored.

It is clear to me that at this session the therapist was not doing psychotherapy. She was in fact exploiting the rational work task of therapy to discharge her own unconscious anxieties that centered on envy. She repeatedly employed projective identification to achieve her ends.

It is notable that some analysts view gaslighting as being rooted in unconscious greed. In the regression from the oedipal impulses some, perhaps many, people retreat to the introjective (oral) mode of defense. Calef and Weinshel have described, under the rubric of "gaslighting," an outcome of the introjective defense in which a victim and a victimizer join psychological modes in expressing and defending themselves against oral, incorporative impulses (greed), each in his or her own way. Calef, V. and Weinshel, E. "Some Clinical Consequences of Introjection: Gaslighting." A significant aspect of this session—worthy of further inquiry—may well be

the playing out of a transference/countertransference enactment in which both the therapist and I defended against oral, incorporative impulses (greed), each in our own way.

Therapy Summaries: January 8 and January 15, 2019

It is a very remarkable thing that the Unconscious of one human being can react upon that of another, without passing through the Conscious. This deserves closer investigation . . . but descriptively speaking, the fact is incontestable.

—Sigmund Freud, “The Unconscious.”

From a psychoanalytic perspective, such “dysfunctions,” as they are commonly called in the world of organizations, are not, strictly speaking, dysfunctional at all; rather they function on “another scene” that sometimes emerges into view; the scene of the unconscious as radically other.

*—Gilles Arnaud, *The Organization and the Symbolic: Organizational Dynamics Viewed from a Lacanian Perspective*.*

In various kinds of social systems, people tend unconsciously to recreate situations (in terms of actions, fantasies, object relations and affects) that have occurred in another time and space, such that the new or later situation may be taken as “equivalent” to the old or previous one.

*—Earl Harper, *The Social Unconscious: Theoretical Considerations*.*

THERAPY SESSION JANUARY 8, 2019

PATIENT: I was thinking about transitional objects, you know, like a kid's teddy bear. They say a transitional object is part me and part non-me. The child projects aspects of himself and mother into the object — that's the me part — but he also recognizes that the object is an object outside himself. And, you know, I have the idea that for me my baby bottle might have been a transitional object. And I am intrigued by the implications of that. Because I told you the story about how I was continuing to drink from my baby bottle even at age three. My mother let me drink milk from the bottle that had gone sour, and I developed a case

of scarlet fever from the spoiled milk. My pediatrician had to call the health department because scarlet fever is a serious public health concern, and the health department had to quarantine our house. So I was aware of these things. I can remember the quarantine notice on our front door. I remember it had an intimidating quality for me, probably from the fact that my parents were angry about it and I internalized their anger about the quarantine notice, which was a kind of scarlet letter on the house.

And what intrigues me is the idea of my transitional object, my baby bottle, coming to the attention of city governmental authorities and what that might have meant for me psychologically. How did I internalize that experience? Think about how unusual that is! A lot of kids have a blanket or a teddy bear. But how often does it happen that a kid's transitional object — his blanket or teddy bear — comes to the attention of governmental authorities, and the authorities actually take action against the family because of the kid's teddy bear or blanket? That's really kind of weird and strange when you think about it.

Well, you know, I've been thinking, and I think about other things in my life that might qualify as transitional objects. Like my letters to you. I have a theory that my letters to you are transitional in nature. I was reading something this last week that ties my letters together with the idea of transitional objects. It's from the New York University Psychoanalytical Institute, no less. They said that there are three components to transitional objects: the transitional object can be a phase in a child's development. It can be a defense against separation anxiety, and, also — and this is what I thought was significant — it can be a private sphere for the child in which his experience is not challenged. And that last thing really struck me: a sphere where the child's experience cannot be challenged. And you know, it reminds me of my letter writing: the

letters I write to you. I mean we have this one-on-one interaction every week where I meet with you personally and I talk and you can challenge what I am saying, but in my letters I am free to say whatever I want and you can't challenge it. Nobody can challenge it. The letters are my private space where I can blend my objective experiences with my subjective impression of my experiences. My letters are part me and part non-me. I mean, I record my recollections of what you actually talk about here at the sessions — that's the not-me part — but then, I talk about my subjective reflections on what we talked about, and that's the me part. It's like a teddy bear: part projection and part objective reality, part me and part non-me. But then, I think about the fact that you seem irritated by my letters, sometimes you seem angry by what I have written. And, you know, I think: "Is that like my baby bottle getting me in trouble with the government authorities, like when I was three years old? Is it possible I need to put my transitional objects — assuming my letters to you are transitional objects — into a public space and arouse antagonism and experience punishment for my transitional objects, in effect, repeating what happened to me when I was three — that is, the way I got in trouble with the government because of my attachment to my baby bottle. . . . You know, I just thought of something. A Woody Allen movie. You've heard of Woody Allen?

THERAPIST: Yes.

PATIENT: So, there's this Woody Allen movie called *Deconstructing Harry*. I first saw that movie in the year 2005 and it had a powerful resonance for me. It's one of my favorite movies. It's about a writer. His name is Harry Block. He writes novels. They're all based on his personal experiences. You know, like with family and friends, etc. But the thing is, he doesn't disguise any of the people that the fictional characters are based on. The people Harry Block knows, who he changes into literary characters, can

recognize themselves in his books. And Harry Block gets into big trouble because of the things he discloses about people in his books. One woman he knows tries to kill him, she's so angry. Her husband found out she had an affair because Harry Block turned her into a character in his novel, but didn't disguise her. Her husband read the book, and he could recognize that the character in the book was actually his wife. So the story is about somebody who takes his creative writings and puts them into a public arena, and in doing that he gets into trouble because of his creative writings. It's like me. I take private stuff and put it into a public arena, like Twitter or on my blog, and I get into trouble. I'm saying maybe my actions fulfill an unconscious need of mine to get punished for taking my inner world and putting it into the public sphere. It's kind of like how my baby bottle, something that was private to me, came to the attention of the governmental authorities and I ended up getting our house quarantined.

I think about Dr. P—, my primary care doctor, who took out a protection order against me in 2016 because of my Twitter page. I was writing about him obsessively on my Twitter page and he read it and he thought I was stalking him. And what's interesting is if you think about my relationship with Dr. P— and my Twitter as transitional phenomena. I was writing imaginary conversations on Twitter between Dr. P— and me. I was creating this continuing fantasy dialogue between him and me — like a little kid talking in private to his teddy bear. The Twitter was part me and part non-me. My fantasies about Dr. P— are part me and part non-me. I see Dr. P— as a real other person, but at the same time I experience a loss of ego boundaries with him. It's as if I can't see where his ego begins and my ego leaves off. That's kind of like the way a kid is with his teddy bear. And I think — and this is crucial — was it necessary for me psychologically to put this transitional phenomenon, that is, my fantasies about Dr. P, into the public arena, that is, publish these imaginary

conversations on Twitter for all the world to see, so that I would get into trouble? Did I need to get in trouble with my Twitter postings about Dr. P— because that's my internal schema? I need to get in trouble as an adult because of my transitional object the way I got in trouble at age three because of my baby bottle and my coming down with scarlet fever and getting in trouble with the government.

[The notion of Dr. P— as an idealized transitional phenomenon finds support in the literature and can be seen to link up with my childhood experience of parental deprivation. For me Dr. P— may be seen as an idealized Other whose objective person matches up with my internal idealized parental images. Holding onto the idealized created image of Dr. P—, like a child holding onto his teddy bear, a transitional object that facilitates a healthier developmental trajectory, perhaps allows me to transcend a reality of parental deprivation. Perhaps, Dr. P— represents the longed-for parental functions that I was denied in childhood in the form of nurturing and protection. My psychological relationship with Dr. P — transitional in nature, that is part me and part non-me — can be seen as a reparative fiction essential for my sense of security.

There is “a process of othering in which the alterity of the other is preserved through attributes of ultimate standards of perfection that are contrasted with the imperfect, inferior self. The binary opposite demarcation between self and other still holds, but the other is altered by aggrandizement and exaltation rather than denigration. In other words, through idealization the object is kept as an image unlike the self.” The author introduces a “notion of reparative idealization” that is contrasted “with the traditional psychoanalytic notion of defensive idealization.” The author argues “that our need for a caretaking parental figure is profound and everlasting. In the absence of nurturing and protective figures in our real-life relationships, we idealize and alter parental internal representations in our minds in order to, at least symbolically, experience the longed-for parental functions. We

are attached to these internal representations. These idealized parental figures are reparative fictions essential for our psychological survival and the lifelong sense of security. Holding onto an idealized created image [like the child holding onto his teddy bear] – a transitional object that facilitates a healthier developmental trajectory and allows one to transcend a reality of parental deprivation—may be a key for adaptation. This is a growth-promoting process, not just a defensive mental maneuver, which seems to be a universal phenomenon.” From the book, Memories and Monsters: Psychology, Trauma, and Narrative edited by Eric R. Severson, David M. Goodman.]

PATIENT: These possibilities intrigue me. And this is what I am thinking about. There is a theory in psychoanalysis that when a child experiences a trauma — and my coming down with scarlet fever when I was three years old might have been traumatic for me — he will develop a need in adulthood to symbolically repeat that trauma in an attempt to overcome the childhood trauma. As an adult he may try to repeat circumstances that symbolize the circumstances of the original trauma as if he were thinking, “If I experience this again, or cause this to happen again, this time I will know what to do to avoid a bad outcome.” But the thing is this reenactment, what’s called the repetition compulsion, never overcomes the original trauma — and the person just keeps repeating these behaviors and recreates situations in adulthood that simply bring about a bad outcome again and again. It’s an unconscious process. What really intrigues me is that psychoanalysts say that a person can unconsciously get other people in his environment to play the needed roles as scripted in the person’s unconscious, his internal drama, through the mechanism of projective identification. That idea fascinates me.

[Repetition compulsion is a psychological phenomenon in which a person repeats a traumatic event or its circumstances over and over again. This includes reenacting the event or putting oneself in situations where the

event is likely to happen again. This “re-living” can also take the form of dreams in which memories and feelings of what happened are repeated, and even hallucination. The term can also be used to cover the repetition of behavior or life patterns more broadly: repetition compulsion describes the pattern whereby people endlessly repeat patterns of behavior which were difficult or distressing in earlier life. Many traumatized people expose themselves, seemingly compulsively, to situations reminiscent—sometimes only symbolically so—of the original trauma. Van der Kolk, B. “The Compulsion to Repeat the Trauma: Reenactment, Revictimization, and Masochism.”

Freud concluded the individual unconsciously arranges for variations of an original theme which he has not learned either to overcome or to live with: he tries to master a situation which in its original form had been too much for him by meeting it repeatedly and of his own accord. Erikson, E., *Childhood and Society*. "Thus one knows people," Freud wrote, "with whom every human relationship ends in the same way: benefactors whose protégés . . . invariably after a time desert them in ill-will: . . . men with whom every friendship ends in the friend's treachery . . . lovers whose tender relationships with women each and all run through the same phases and come to the sane end, and so on." Freud, S., *Beyond the Pleasure Principle*. Freud emphasized the perverse gratification that the neurotic experiences upon re-experiencing the traumatic event from childhood. The repetition compulsion is a way of turning passive into active, an attempt at mastery as if the person were thinking, "this time things will turn out well." But the hurtful outcome is always the same.]

THERAPY SESSION JANUARY 15, 2019

[After about 20 minutes, the following discussion ensued:]

THERAPIST: So last time you were talking about transitional objects.

PATIENT: So yes, last time we were taking about transitional phenomena and I talked about my sense that Dr. P–, or my imagining of him, was a transitional object for me, like a child’s teddy bear. And then, you know, last week, I read an article about this very issue. It was written by a psychoanalytically-trained social worker. He writes about this concept he called “mindsharing.” He talks about Winnicott’s ideas about transitional objects, like the thumb, or blanket, or teddy bear, and how transitional objects are imbued with aspects of the child’s idealized self and his idealized imagining of his mother but are also external to himself. And the author talks about how this relates to Kohut’s ideas about selfobjects – these are people who narcissistic people, like me, need to compensate for missing parts of themselves. It’s useful to think of a selfobject as a kind of kidney machine for a person with kidney disease whose kidneys aren’t functioning. So there’s this machine external to the self that is hooked up to the individual and the machine takes the place of the person’s diseased kidneys. So the person with the machine has the functioning of a normal person with healthy kidneys. And Kohut’s idea is that some narcissistically-disturbed people have things missing in their personalities and they are drawn to these people called selfobjects that psychologically compensate for the things missing in the narcissistically-disturbed person.

[In Kohut’s theory, the term selfobject refers to, or attempts to describe, a psychological function that another performs for the subject and the subject requires in order to maintain what we may describe as a sense of

well-being, a homeostatic inner balance, or a cohesive sense of self. The selfobject shares part of another person's psychic organization. Palombo, J. "Mindsharing: Transitional Objects and Selfobjects as Complementary Functions." The author introduces the term, "mindsharing" that allows him to compare similarities between Winnicott's transitional object and Kohut's notion of the selfobject.

"Mindsharing may be defined as a form of intersubjectivity in which one person provides psychological functions that complement, and are essential to the maintenance, the integrity of, the sense of self of the other person. The interchanges between such dyads, at times, may be reciprocal. The experience of 'being with' or feeling intimacy with another person is constitutive of mindsharing." The author goes on to state that in mindsharing the psychological equipment of one individual is complementary to that of another. "Examples of this sense of the term mindsharing are the use of the transitional object (Winnicott), the performance of auxiliary ego functions (Spitz), and selfobject functions (Kohut). In each of these functions either the presence of a person or an internal representation of a function that person performs is necessary of the other person to be able to maintain a sense of inner psychological stability and integrity, which I refer to as self-cohesion. I assume that understanding what is on another person's mind, explicitly or implicitly, is a necessary condition for self-other complementing. Mindsharing as a form of mental state sharing and tuning serves not only to complement but also to transform the inner state of another person. Such are the dual functions that empathy performs. It not only serves as an instrument through which we can grasp another person's inner state but also provides a human milieu that is experienced as benignly caring." Palombo, J. "Mindsharing: Transitional Objects and Selfobjects as Complementary Functions.]

PATIENT: I feel that very much with Dr. P-. When I fantasize about him I have a feeling of wholeness and completeness. I feed off the sense that he mirrors me, that he is an alter ego for me. That my merger fantasy with him makes me a whole person and I get a sense of completeness. Like a kidney patient on a kidney machine; when he's hooked up to the machine he becomes a normally-functioning person.

[At a later point in the session I digressed to a seemingly unrelated topic, namely, my longstanding beliefs about my former employer that have been termed delusional by my therapists. Indeed, two of my psychiatrists diagnosed me with paranoid schizophrenia because of my belief that I have been under surveillance by my former employer, the Washington, D.C. office of the international law firm of Akin Gump Strauss Hauer & Feld.

A brief summary of my beliefs about the surveillance are as follows. In late October 1988, while working at the firm I wrote a psychoanalytical study about myself that I called "The Caliban Complex." I had started working at the firm months earlier, in March 1988 as an agency-supplied temporary employee. I transmitted the paper to three former coworkers at my last employer, including my friend, Craig Dye. Days later I sensed a hubbub at Akin Gump that prompted me to assume that Craig had surreptitiously provided someone at Akin Gump the paper I had written. I telephoned my sister at about this time; her distressed manner suggested to me that she was reacting to a possible communication from someone at Akin Gump. When I was hired directly by the firm in June 1988 I had provided Akin Gump my sister's telephone number as an emergency contact.

There are objective reasons Akin Gump might have been concerned or curious about me. First, in the firm's own words, I was "a law school

graduate performing paralegal or administrative duties.” I had an advanced law degree in international trade, a major practice area of the firm. When I was hired I had provided the firm several glowing letters of recommendation from a former law employer (Thomas W. Jennings, Esq. and Stephen F. Ritner, Esq.) as well as a recommendation from a leading expert in international trade law (Seymour J. Rubin, Esq.). If Craig Dye had in fact transmitted a copy of my psychoanalytical study to the firm, I would undoubtedly have presented an unusual and intriguing case to the firm – a licensed attorney with considerable professional potential who was not practicing law, but who wrote a psychoanalytical study about himself.

Incidentally, I subsequently learned that the firm's co-founder, Malcolm Lassman, Esq., was a “personal friend” (in the firm's words) of the late Gertrude R. Ticho, M.D., an internationally-renowned psychoanalyst and personal friend and mentor of Otto Kernberg, M.D., past President of the International Psychoanalytical Association as well as a recognized expert in psychodynamic group theory. Notably, my former treating psychiatrist, Stanley R. Palombo, M.D. told me that my woefully underemployed status had doubtless rendered me a “freak” and a “buffoon” in the eyes of the employer. Why wouldn't the firm have been curious about me? Why wouldn't the firm have tried to learn more about me?

Additionally, I appeared to be socially isolated at the firm, which boasts a well-known casual and friendly work atmosphere. I had the sense that my social isolation at the firm was noticed. On one occasion in June 1988, shortly after I was hired, the attorney in charge of the firm's paralegal program, Earl L. Segal, Esq. accosted me in a bizarre and confusing manner as we rode alone on an elevator one evening. He kept repeating the phrase, “Isn't this fun? Isn't this fun?” I had no idea what he was talking about. I said: “Isn't *what* fun?” He replied, “This! THIS!!

Isn't this fun?" That interaction as well as several contemporaneous peculiar interactions with other of the firm's partners, including David P. Callet, Esq. and David Hardee, Esq., led me to believe that the firm was a loony bin. Incidentally, both Earl Segal and David Callet were alumni of my college alma mater, Penn State.

In early January 1990 I formed the belief that some individual(s) from Akin Gump had been permitted by the apartment manager (Elaine Wranik) to enter my residence. I believed that the individual(s) inspected the apartment, including my many books, and took a videotape of the apartment. I believe that the firm sent a copy of the videotape to my sister. Oddly, in early November 1991, days after the firm terminated me, I got into an argument with Wranik in my apartment about a routine maintenance matter. At the height of the argument, I threatened Wranik, stating, "My sister still has that videotape!" Immediately, Wranik replied, "I have pictures too." I found Wranik's statement odd and suspicious. *I have pictures too?* I would have expected her to say, "What videotape? What are you talking about?" No, she said simply, "I have pictures too." Indeed, since Wranik had become apartment manager in about 1986, she occasionally inspected my apartment when I wasn't home because I had a history of having a messy apartment. She sometimes left me notes telling me to clean up. On one occasion she showed me pictures she had taken of my apartment to document the unit's condition.

On the afternoon of April 16, 1990, during the period I was in psychotherapy with Stanley R. Palombo, M.D., I formed the belief that Akin Gump had arranged that J.D. Neary, Akin Gump's paralegal coordinator, meet with Dr. Palombo to "tell his side of the story" about me. I formed the belief that I was not supposed to find out about that surreptitious consult between Neary and my psychiatrist.

I wrote about the presumed consult in a post I published on my blog, My Daily Struggles, dated November 18, 2009:

On Monday afternoon April 16, 1990 the legal assistant coordinator at the law firm where I worked, J.D. Neary, met with my psychiatrist, Stanley R. Palombo, MD, at his office. It was a stealth visit arranged by my employer, the DC law firm of Akin, Gump, Strauss, Hauer & Feld. I was never supposed to find out about the visit. But I did. One of my special powers is to read the meanings of trivial events in my environment. The world-renowned psychiatrist, Gertrude R. Ticho, MD, in fact, affirmed that I read a meaning in trivial events. She never actually said I read an incorrect meaning in trivial events, to the best of my knowledge – simply that I attach a negative meaning to trivial events. Dr. Ticho's professional opinion leaves open the possibility that I accurately read the negative meanings of trivial events. Yes, that's my special power.

So, in my deluded belief system, J.D. Neary saw my psychiatrist on Monday afternoon April 16, 1990. J.D. Neary told Dr. Palombo about my messy, junk-strewn apartment. You see, my employer had gone to my apartment in early January 1990 – it was the first workday after the New Year; the exact date escapes me now. It had been a stealth operation. A couple managers of the firm got the apartment manager Elaine Wranik (now sadly departed) to let them in my apartment. They came with a video camera and taped my apartment. The resulting video was not exactly Oscar material. The managers sent a copy of the videotape to my sister.

Dr. Palombo's professional opinion was that J.D. Neary's comments about me were a projection of his own anality.

I remember that late in the afternoon of Monday April 16, 1990 my supervisor, Chris Robertson, held an impromptu staff meeting. Chris Robertson and the other

supervisory staff had been thoroughly discombobulated by Dr. Palombo's opinion about J.D. Neary. My curiosity was aroused by the fact that my supervisor had called a largely unnecessary, previously unscheduled meeting – late in the afternoon – to talk about the need for employees to cut down on the amount of junk in their environs. She talked about the managing partner, Larry Hoffman, going around the firm and videotaping all the junk that employees had accumulated in their workspace.

With the help of my special powers, I knew what Chris Robertson was actually talking about. She had been overstimulated by the news about J.D. Neary's visit to Dr. Palombo and she needed to discharge that overstimulation.

I believe that Kleinian theory can confer meaning on the above anecdote, in which the Akin Gump group dynamics, specifically the regressed group dynamics of the paralegal and litigation support staff, comprise the backstory.

My notions about this incident—namely, the firm's decision to have Neary consult Dr. Palombo in April 1990 as well as my supervisor's possible response to Dr. Palombo's presumed subsequent report to the firm—center on the issues of paranoid-schizoid anxiety, idealization of the good object, devaluation of the bad object, regressed group dynamics, and the mechanism of projective identification—issues of psychoanalytical concern that are at the core of Melanie Klein's work and that of her successor, Wilfred Bion.

Otto Kernberg, employing Kleinian ideas about group dynamics, has written: "The psychology of the group . . . reflects three sets of shared illusions: (1) that the group is composed of individuals who are all equal, thus denying sexual differences and castration anxiety; (2) that the group is self-engendered – that is, as a powerful mother of itself; and (3) that the

group itself can repair all narcissistic lesions because it becomes an ‘idealized breast mother.’” Kernberg, O.F. *Ideology, Conflict, and Leadership in Groups and Organizations*.

I believe I was Othered in this group because of my autonomy; I had not lost my individuality, my thinking or my rationality. I was not an “equal” of in-group members; I was not de-differentiated, that is, I had not assumed a homogenized group identity. I did not share the in-group’s unconscious feelings and fantasies. As the firm said, “There was a lack of fit between me and firm personnel.”

S.H. Foulkes described four levels of relationships and communication in a group: (1) the current level – everyday relationship in which the group represents the reality, community, social relationships and public opinion. The conductor is perceived as a leader or authority; (2) the transference level – corresponding to mature object relations, where the group represents the family, the conductor is perceived as a parent and the group members as siblings; (3) *the projective level – corresponding to primitive object relations of part-objects with projected and shared feelings and fantasies.* Members can represent elements of the individual self. The group represents the mother image or even her womb, and body images are reflected and represented by the group and its members; and (4) the primordial level – the group represents shared myths, archetypical images and the collective unconscious. Foulkes, S.H., “Access to Unconscious Processes in the Group Analytic Group.”

Michael Diamond has described the regressed psychodynamics found in the so-called “homogenized group”: “The homogenized group is the most primitive and regressed collective response to basic (annihilation) anxiety. Its predominant characteristic is the lack of self-object differentiation, where ‘normal autism’ and ‘symbiosis’ persist as developmental

forerunners to the earliest separation-individuation phase. Individuation is absent. Similar to the nascent self of the infant who is merged with and anxiously attached to the love object, mother, individual members of the homogenized group are as one. Members experience unusual difficulty in distinguishing between self and other and have great difficulty in achieving meaningful interaction with each other. Such primitive conditions symbolize infantile regression. Group members are cut off from external object relationships and become detached and withdrawn [from the rational, real world outside the group]. A shared collective unconscious wish to return to the safety of the womb to avoid the group's hostile environment is realized by group members in this culture. Members often experience the same feelings and act similarly, an illusion of security in a culture of sameness." Diamond, M.A. and Allcorn, S. "The Psychodynamics of Regression in Work Groups." For Diamond, *withdrawal* in homogenized groups connotes an internal resignation into a self-object world of fragmentation and splitting of oneself and others into absolutes of good and bad, love and hate, accepting and rejecting, and so on. Diamond, M.A. "The Symbiotic Lure: Organizations as Defective Containers."

At Akin Gump I worked in a homogenized group of paralegals and litigation support staff that had assumed a group identity dominated by paranoid-schizoid anxiety: the splitting of and projection onto objects of "all good" and "all bad" images. Indeed, when Akin Gump hired me in June 1988 the paralegal administrator, Margarita Babb said to me, "The paralegals at this firm tend to be very cliquish; they might not accept you." Paralegal coordinator Neary was idealized by group members (including Robertson) as an all-good object. Neary was not simply the basic assumptions group leader—to use Bion's term—but, in a sense, an exemplar of the group identity, the all-giving breast mother. What Dr. Palombo had done, in effect, was to tarnish the image of the all-good

object and, by implication, reduce my suitability as the all-bad object, or scapegoat. Dr. Palombo's communication to the firm after his consult with Neary caused a severe anxiety state in Robertson (annihilation anxiety?) in which her good object (Neary) was tarnished and her bad object (me) was revalued, which might have resulted in her having to face her bad internal objects without the possibility of expelling them to the scapegoat outside. Keep in mind, as Diamond points out: the shared illusion of the homogenized group, i.e., the shared splitting of and projection onto good and bad objects, is a defense against annihilation anxiety. Dr. Palombo's presumed communication to Akin Gump about Neary might have been experienced by group members as an assault on the group's defense against annihilation anxiety. Remove or impair the defense, and group members will be flooded with annihilation anxiety. Dr. Palombo's communication to the firm might have traumatized, or was seen to harm, the idealized regressed group identity with which members identified: a shared identity in which the in-group and its leader (Neary) were seen as all-good. One is reminded of the passions of President Trump's supporters. Have you ever criticized President Trump to a Trump supporter? You will arouse a fury.

According to theory, when social identity is salient (as in a homogenized group), group members perceive themselves as exemplars of the group and events that harm or favor the group harm or favor the self. When social identity is salient, appraisal of events relevant and important to the group focuses on social rather than personal concerns. Group-based appraisals elicit specific emotions and action tendencies. Group members feel happy, sad, or traumatized depending on the successes or failures of the in-group with which they identify, even if they do not personally contribute to that outcome. Kira, I.A., et al. "Collective and Personal Annihilation Anxiety: Measuring Annihilation Anxiety AA."

My conjecture is that the particular anxiety that Robertson was attempting to force into me via projective identification at the staff meeting she held on the afternoon of Monday April 16, 1990 was annihilation anxiety based on her perceived threat to the regressed (idealized or all-good) in-group identity. In the group context annihilation anxiety is a terror of losing the social self or selves as a result of identity, personal and/or collective/group's survival threats. Such anxiety emerges from fears that one or more of the self salient identities will be subsumed, devoured, dissolved or fused, penetrated, fragmented, destroyed, disappeared or subjugated, due to real or perceived threats to such salient identities' survival. Kira, I.A., et al. "Collective and Personal Annihilation Anxiety: Measuring Annihilation Anxiety AA."

Perhaps the above anecdote relating to the events of April 16, 1990 was related to the events of the day of my termination (October 29, 1991) when I reacted to news of my termination in a mature and a professional way. When the firm advised me that I was being fired, I simply packed up my belongings without protest and left the premises, despite abundant reasons to be angry. Only months earlier, in May 1991, my supervisor had written in a performance evaluation that I was "as close to the perfect employee as it is possible to get" and that I was "a team player." My supervisor, Robertson was present at the termination meeting where she observed my behavior. In effect, my mature and professionally-responsible conduct at the termination meeting denied Robertson a bad object, or scapegoat, on which she could project, which might have triggered her rage – leading to her ultimately planning a staff meeting (which she typically did when she was anxious, as on April 16, 1990) and telling employees that she feared that I might return to the firm to kill (annihilate) her and her staff.

I note that similar dynamics seem to occur in racism when a racist is confronted with an accomplished black person who thus denies the racist

an object on which she can project her bad objects. In order for the racist to feel “all good” she needs a devalued object to be “all bad.” Thus, a successful black person threatens the racist’s *identity*, his idealized conception of himself as all-good.

About Robertson’s staff meeting on October 29, 1991, Patricia McNeil, a coworker, later stated to me: “The only thing I knew is that Chris [Robertson] sent the email over the system, and *she wanted all of us in the office*, and the next thing, she said, ‘no, forget about it.’ She said, ‘Well, you all know that Gary, he’s gone, and they’re coming to change the locks because Gary may come back and he may kill me or something.’ *All I know, Chris [Robertson] called a meeting.* She had sent an email. And then, all of a sudden, she canceled the meeting. She just said, ‘Oh.’ And she said, ‘they’re coming to change the locks. They should be down here because we’re afraid he may come down here and try to kill us or something.’” Tellingly, Akin Gump did not contact the police. Incidentally, Robertson was a court-adjudicated racist. Federal court testimony in subsequent Title VII litigation concerning a terminated black employee disclosed that Robertson had a history at the firm of racist conduct toward black employees. Indeed, it was my own discrimination complaint against Robertson that I filed with Akin Gump’s senior managers on October 23, 1991 that triggered my sudden and suspicious termination only days later.

Be that as it may.

I have become curious about how, perhaps, the Akin Gump in-group’s presumed projective identification during the three-year period of my employment—an essential psychological ingredient of the workplace mobbing I was exposed to at the firm—aroused feeling states in me over time in which my idea that I was under surveillance by the firm can be

seen as a transitional phenomenon – an attempt to merge subjective distressed feelings that were being forced into me via projective identification with, on the other hand, my perceptions of external, or objective, reality.

Are Winnicott's ideas at all applicable to this problem?

“From birth therefore the human being is concerned with the problem of the relationship between what is objectively perceived and what is subjectively conceived off.] The intermediate area [i.e., the transitional object-thumb, blanket, teddy bear, etc.] to which I am referring is the area that is allowed to the infant between primary creativity and objective perception based on reality testing. The transitional phenomena represent the early stages of the use of illusion, without which there is no meaning for the human being in the idea of a relationship with an object that is perceived by others as external to that being.” Winnicott, D.W., “Transitional Objects and Transitional Phenomena—A Study of the First Not-Me Possession.”

Might we say that the “illusion” that Winnicott refers to is what my psychiatrists have called my paranoid delusion that I have been under surveillance by Akin Gump? As with any transitional phenomenon, my surveillance fantasy is both reality and fantasy, subjective and objective at the same time. Ogden, T.H. “On Projective Identification.”

At the therapy session on January 15, 2019 I told the therapist: “I am intrigued by the way my fantasy of being under surveillance matches up with reality in crucial ways. For example, I formed the belief that I was under surveillance in late October 1988. I wondered who could have been directing the surveillance at the firm. This question plagued me for months. I had various theories about who it could be. At one point in

mid-1989 I thought that perhaps senior firm manager Richard Wyatt, Esq. was talking to my sister; unaccountably, Wyatt (with whom I was not acquainted) routinely eyed me with a seeming look of admiration. Over time I developed the idea, based on cues I picked up in the environment, that it was firm co-founder, Malcolm Lassman, Esq. who was talking to my sister. Then in September 1989 I was at my sister's house, and I was bragging about how smart I was, and I said, 'I can prove to you how smart I am. I know who you've been talking to at the firm.' And she said, 'Who?' And I said, 'It's Malcolm Lassman.' And you know, she seemed shocked and she said, 'You *are* smart.' So she seemed to confirm that she was talking to Malcolm Lassman about me. And that's remarkable. First, how would I know that I was under surveillance at all? And if my suspicion was purely paranoia, how could I have pinpointed the exact person my sister was talking to? Keep in mind that the firm has about 400 employees. That's like picking out a needle in a haystack."

Again, might we say that my surveillance fantasy is both reality and fantasy, subjective and objective at the same time as with any transitional phenomenon?

Keep in mind that beginning in adolescence and continuing into adulthood transitional objects – like a child's thumb, blanket or teddy bear – lose their concrete nature and assume an abstracted, ideational quality. Lerner and Ehrlich write: "The specific form of transitional phenomena will differ at each stage due to maturational and developmental shifts in cognitive functioning, libidinal focus, affect organization, and the demands of the environment. The level of cognitive maturity as well as other dimensions of personality become particularly important in determining and delimiting the manifest forms of transitional phenomena. As other functions including self and object-representations become increasingly differentiated, transitional objects are thought to become increasingly less tangible and more abstract. For

example, in contrast to the transitional objects of early childhood, the transitional phenomena of adolescence such as career aspirations, music, and literature are more abstract, ideational, depersonified, and less animistic. They are also increasingly coordinated with reality. Rather than the concrete fantasy representation, it is the ideas, the cause or the symbolic value that becomes important.” Lerner, H.D. and Ehrlich, J., *Psychodynamic Models*.

An open question is whether a seeming paranoid delusion – such as a fantasy of being under surveillance – might qualify, in Lerner and Erhlich’s definition, as a transitional object?

I am fascinated by a striking notion. Is it possible that my discussion early in this psychotherapy session of my idealized psychological relationship with my former primary care doctor, Dr. P–, which I termed a transitional phenomenon or a “selfobject” relationship— can be seen to be related in some way to the psychodynamics of my so-called delusional fantasy of surveillance by Akin Gump? Is there a connection between the “mindsharing” aspect of my fantasies about Dr. P–, on the one hand, and the psychological relationship between me and my Akin Gump coworkers and supervisor, Robertson, on the other, in which *projective identification* (that is, the unconscious forcing of others’ mental contents into the self) was presumed to have played a vital role?

In the case of Dr. P– I spoke at the therapy session about the sense in which I felt connected to him psychologically, a state in which there was a blurring of ego boundaries between him and me. *I sensed a match between his objective person and my idealized internalized good objects.* My workplace mobbing situation seemed to feature projective identification as both a primitive mode of interpersonal communication and a primitive type of object relationship, a basic way of being with an object that was only partially separate psychologically. Projective identification is a transitional form of object relationship that lies between the stage of the subjective

object and that of true object relatedness. Ogden, T.H. "On Projective Identification." Was my relationship with Dr. P— a transitional form of relationship that lied between the stage of subjective object and that of true object relatedness? May we say that my sense of him was an illusion: a merger of the external object of his person with my pre-existing idealized internal object – part me/part non-me, like the transitional object? Might *we also that my surveillance fantasy also relates to a primitive type of psychological sharing between me and my work environment in which the in-group's attempts to force annihilation anxiety into me via projective identification matched up with my pre-existing bad internal objects?*

It is well to keep in mind that the sharp distinction between the internal and external realities is a false dichotomy: the two are integrated and co-constructed, creating one combined fabric. Shoshani, M., et al., "Fear and Shame in an Israeli Psychoanalyst and His Patient: Lessons Learned in Times of War."

Kleinian theory posits an ongoing leakage of an individual's internal world into the world of external objects and *vice versa*.

"Early internal objects of a harsh and phantastic nature (bad objects) are constantly being projected onto the outside world. Perceptions of real objects in the external world blend with the projected images. In subsequent reinternalization the resulting internal objects are partially transformed by the perceptions of real objects. Harsh superego figures actually stimulate object relations in the real world, as the individual seeks out allies and sources of reassurance which in turn transform his internal objects. The individual constantly attempts to establish external danger situations to represent internal anxieties. To the extent to which one can perceive discrepancies between internally derived anticipations and reality, to allow something new to happen, the internal world is

transformed accordingly, and the cycle of projection and introjection has a positive, progressive direction. To the extent to which one finds confirmation in reality for internally derived anticipations, or is able to induce others to play the anticipated roles, the bad internal objects are reinforced, and the cycle has a negative, regressive direction.” Greenberg, J.R. and Mitchell, *Object Relations in Psychoanalytic Theory*.

Is it possible that in the Akin Gump workplace my coworkers and I were engaged in a complementary dance in which I had a psychological need to introject the in-group's anxiety, while the group, in turn, had a psychological need to expel its anxiety onto me via projective identification? Did in-group members attempt to force annihilation anxiety into me to preserve their narcissistic balance even as I attempted to seek out the in-group members' psychological aggression to try to establish an external danger situation that represented my pre-existing internal anxieties?

I am reminded of Calef and Weinshel's observations about gaslighting as being rooted in unconscious greed. In the regression from the oedipal impulses some, perhaps many, people retreat to the introjective (oral) mode of defense. Calef and Weinshel have described, under the rubric of “gaslighting,” an outcome of the introjective defense in which a victim (“the container of anxiety”) and a victimizer (“the expeller of anxiety”) join psychological modes in expressing and defending themselves against oral, incorporative impulses (greed), each in his or her own way. Calef, V. and Weinshel, E. “Some Clinical Consequences of Introjection: Gaslighting.”

I propose that my idealized fantasies about Dr. P—complement my experience of job harassment and possible surveillance in the workplace. With Dr. P—I attempt to create a transitional space in which his objective

person matches my *internal idealized good objects*. Whereas, in the case of the Akin Gump workplace, I might have sought out an external danger situation in my work environment that matched the pre-existing anxieties associated with my *internal bad objects*.

Finally, I will point out something that might be more than incidentally interesting. It is striking that both my difficulties in the Akin Gump workplace and my interaction with Dr. P— culminated in the filing of apparently perjured sworn statements against me. Following my job termination by Akin Gump, I instituted a discrimination complaint against the firm. There is persuasive circumstantial evidence that the Response filed in May 1992 by the employer with a state human rights agency was false or perjured. Likewise, Dr. P— filed an apparently perjured affidavit with a state court to obtain a protection order against me in July 2016. We are faced with an uncanny possibility – consistent with the repetition compulsion – that the filing of these perjured statements with state entities is psychologically related to the incident from my early childhood, namely, my pediatrician advising the Philadelphia Health Department (a government entity) of my scarlet fever infection at age three, and the Health Department's subsequent act of quarantining our house.

Excursus: An Enemy of the People

When I was three years old I contracted scarlet fever, an infectious disease. My pediatrician, Joseph Bloom, M.D., diagnosed the illness during a house call. The doctor was “directly aware, too, of the origin of the infection,” which he attributed to my drinking spoiled milk from a baby bottle; my mother had indulged my taste for spoiled milk.

—*The Dream of the Intruding Doctor.*

Dr. Bloom explained that he was required to report my scarlet fever, deemed a serious public health concern, to the Philadelphia Department of Health.

Thereafter, the Health Department quarantined our house, posting a notice on the front door: “No one other than family members may enter this premises.” The affair – the involvement of government authorities – was a cause of serious embarrassment to my parents.

—*The Dream of the Intruding Doctor.*

I was terminated days after I lodged a harassment complaint against a racist supervisor. The employer later alleged in an apparently perjured sworn statement it filed with the government that I was fired because of severe mental problems: reportedly, I had delusions of persecution, frightened my coworkers, was potentially violent in the opinion of a psychiatric consultant, and – according to my direct supervisor – potentially homicidal. (The employer never contacted the police, by the way!)

—*Therapy Session on May 29, 2018.*

Didn't he try to have a perfectly sane [intelligence officer] certified as insane because he described the commandant as visiting a foreign military attaché ?

—*The Life of Emile Zola (referencing the Dreyfus case).*

In conversations with other analysts close to the Freud family, I was given to understand that I had stumbled upon something that was better left alone. (This was made even more apparent when my connections with the Freud Archives were suddenly terminated).

—Jeffrey Masson, *Freud and the Seduction Theory*.

I accuse the government, I accuse the military, I accuse The Powers that Be of lying and corruption and deception of those whom they would proclaim to serve, the public.

—Emile Zola, *J'Accuse . . . !* (referencing the Dreyfus case).

Who are The Powers that Be?

—Judge Ellen Segal Huvelle, *U.S. v. Jawad*.

THERAPIST: Tell me, who are some of your heroes?

PATIENT: Well, I would say . . . Gandhi, Martin Luther King, . . . Leon Trotsky.

THERAPIST: Leon Trotsky? Why Trotsky?

PATIENT: He defied Stalin.

THERAPIST: Weren't all those people assassinated?

PATIENT: Yes.

THERAPIST: No wonder you have problems with people.

—*Fictional Therapy Dialogue*.

Adverse childhood experiences such as neglect and abuse have been shown to have a significant and far-reaching negative impact. At the same time, recent research has shown that adverse childhood experiences can boost the affected child's personality strengths, including resilience and creativity. One researcher states: "Most of the young people we work with develop skills through pursuit of their own survival. A number of young people have experienced trauma in their childhood, and have been compelled to find strategies to cope. Some become very independent as a result, because they can't rely on anyone in the household to look after them."

Researchers have found that individuals with more violent lives were better at remembering relationships based on social dominance—such as who might win a fight. This suggests people living under harsh conditions may be able to hold their own, or even excel, when solving problems in which the content is relevant to their lives. These findings provide some evidence of "hidden talents" linked to adversity. One study found that children who had four or more adverse childhood experiences had significantly stronger creative experiences, appeared to be more aware of the creative process and were more deeply absorbed in it than peers with no or fewer adverse childhood experiences. Thomson, P. and Jaque, S.V., "Childhood Adversity and the Creative Experience in Adult Professional Performing Artists."

In this book I have elaborated notable adverse experiences from childhood and as an adult. I grew up in a dysfunctional family that featured scapegoating; a violent father; excessive authoritarian control; parents who were overly-critical, punitive, judgmental, and intrusive; and intergenerational trauma. As an adult I experienced three-and-a-half years of workplace harassment at a law firm where I worked as a paralegal. That employment culminated in a sudden and unjustified job termination; I was later defamed by my former employer as severely disturbed and potentially dangerous. My direct supervisor—a known

racist—who, months before had described me as being “as close to the perfect employee it is possible to get” told her employees on the day I was fired that she was afraid I might return to the firm’s premises to kill her and my former coworkers.

In the period after I was fired I began work on an experimental autobiographical book that I titled *Significant Moments*. In April 1993 I happened to see a public television broadcast of Anna Deavere Smith’s one-person play, *Fires in the Mirror*, which explores the viewpoints of people from Black and Hasidic Jewish people based in New York City who were connected directly and indirectly to the Crown Heights riot that occurred in Crown Heights, Brooklyn in August 1991. I was spellbound by Smith’s use of so-called verbatim theater, a form that uses interviews and pre-existing documentary material (such as newspapers, government reports, journals, and correspondences) as source material for stories about real events and people, frequently without altering the text in performance. Verbatim theater privileges subjectivity over universality and questions the definition of truth. In verbatim theater the playwright interviews people who are connected to the topic that is the play’s focus and then uses their testimony to construct the play. In this way, the playwright seeks to present a multi-voiced approach to events. In the days after I saw *Fires in the Mirror*—and inspired by the structure of Smith’s one-person play—I composed a first draft of *Significant Moments*, a writing that collated quotations from existing historical and literary texts. I became consumed with the writing of the book and spent the next eleven years working on it.

Can we trace my creative talents and creative motivations to early adverse experiences in my family? That is the question I address in the following essay, “An Enemy of the People.” The following essay is essentially a paraphrase of a technical psychoanalytic paper titled, “Ibsen: Criticism, Creativity, and Self-State Transformations” by Frank M. Lachmann and

Annette Lachmann, published in *The Annual of Psychoanalysis*, vol. 24, in 1996.

A measure of a person's creativity, so the psychoanalysts say, is the ability to transcend the slings and arrows of outrageous critics. To be able to form a work of art out of the rubble left by such an attack is, of course, not the only way in which creative abilities can show themselves, but it is one way. I chose my view of creativity, the capacity to turn a humiliating rebuff into a triumph, for two reasons. First, it has been proposed as a developmental ideal in that it signals one of the transformations of archaic narcissism. Second, it is of particular relevance in providing a glimpse into my creative process. Specifically, I refer to my response to the criticisms and rejections of my former employer, the law firm of Akin, Gump, Strauss, Hauer & Feld, by writing my autobiography, which I titled *Significant Moments*. In focusing on this view of creativity, I necessarily ignore other factors that contribute to artistic creativity.

I transcended my reaction to the devastating job termination and its aftermath by creatively transforming that experience in *Significant Moments*. At Akin Gump I confronted central themes that had been haunting me since childhood, ghosts from the past in their purest, boldest form: my search for an idealizable father-figure (in the person of the eminent lawyer, Robert Strauss), social rejection, the jealousy of coworkers (symbolic siblings), allegations that I posed a physical danger to others, the lack of empathy of peers and superiors, the appearance of anti-Semitism, and the vague impression of a corrupt organization. Having suffered for three-and-one-half years in a difficult job situation, I was in a particularly vulnerable position when attacked by the employer and ignored by potential supporters. In *Significant Moments*, I depicted my outrage at my former employer and coworkers, redressing the narcissistic injury I had sustained. I triumphed over my detractors through a complex

self-restorative solution. I argued for an extreme, defiant, uncompromising stance through which the artist can defy social pressure and withstand ridicule and isolation; in my creative transformation I displaced my personal conflicts ~ both intrapsychic and interpersonal ~ onto societal conditions.

The conscious acceptable "enemy" for me would become an impersonal set of unjust and corrupt conditions, and the means of battle would be waged largely in words within the controllable arena of social conscience within a work of art.

My thesis is that one function of the creative process is to transform one's depleted self-state in response to a narcissistic injury. I propose that my own self-state transformation was based on motivations encapsulated in a model scene, which I inferred from a selection of recollections. A discussion of self-states and model scenes follows. The model scene links organizing themes inferred from my life and my book with the self-state I attempted to recapture after the narcissistic injury incurred by the job termination.

SELF-STATES AND THEIR TRANSFORMATION

My use of the term self-state draws on contributions from several sources: Stern's and Sander's discussions of state transformation and the self-regulating other and Kohut's discussion of self-states as noted in self-state dreams.

When used by infant researchers, state refers specifically to variations in sleep and wakefulness that occur as the infant passes between crying and alert or quiet activity, drowsiness and sleep, wet discomfort and dry discomfort, hunger and satiation. Different states affect how things are perceived, how those perceptions are integrated, and how such information is processed.

State transformations in early life accrue to both the child's self-regulation and to the expectation that mutual regulation with the caretakers will facilitate or interfere in regulating one's affects and states. Thus, early state transformations are associated with mastery or control over one's own experience, and expectations that affect regulation can (or cannot) be shared with the self-regulating other.

With the advent of symbolic capacities and increasing elaboration upon one's subjective experience, self-states in the child and adult include the domain of the self in a psychological sense. Post infancy self-state transformations may increase a sense of control, mastery, or agency, but in the case of traumatic self-state transformations, such states as devastation, outrage, or fragmentation may become dominant.

The subjective discomfort of painful self-states provides an impetus for finding means by which such states can be transformed. A creative endeavor, one means of transforming one's self-state, enhances the range of the self-regulation. Furthermore, in the context of mutual regulations, expectations of a responsive environment shift the state of the self along the dimension of fragmentation-intactness toward greater cohesion and along the dimension of depletion-vitality toward an increased sense of efficacy.

Kohut described self-state dreams in which the imagery is undisguised or only minimally disguised, depicting the dreamer's sense of self. Kohut likened these dreams to Freud's discussion of dreams in traumatic neuroses, in which a traumatic event is realistically depicted. For example, a self-state may be depicted in a dream as a barren countryside, reflecting a sense of devastation and such self experiences as depression, despair, or hopelessness.

My use of self-state is broader than Stern's since I extend my perspective

into adult life, and my use of the term is not confined to the dream imagery described by Kohut. Dream imagery provides a glimpse into a person's feelings of devastation and outrage, but the imagery of narratives can also convey self-states.

MODEL SCENES

To construct the model scene that depicts the self-state that I attempted to recapture after I was subjected to devastating criticism in the form of job harassment, job termination, and defamation, I combined facets of my life history.

For the first several years of my development, I experienced a childhood characterized by an overprotective but unempathic mother and a distant, but at times harsh, father. My father, born in 1906, was a highly-intelligent man who settled for far less in life than he was capable. He had quit an academic high school restricted to college-bound students in the tenth grade, and, in adulthood, worked in factories. Though he was raised in a strictly Orthodox Jewish family, he was the only one of seven children to marry outside the Jewish faith, in 1946. My mother was a Polish-Catholic whose father, an immigrant coal miner, died in the great swine flu epidemic following World War I. My father suffered both overt and covert anti-Semitism from my mother's family during the marriage—itself a form of criticism. My father coped with the attacks directed at him by relying on a deeply-rooted sense of his cultural and religious superiority.

My mother doted on me, but paradoxically, had a tendency to negligent, even reckless, caretaking. At age three I developed scarlet fever, an unusual bacterial disease. I was late in being weaned from the bottle. Though I ate solid food by age three, of course, my mother indulged my desire to drink milk that had gone sour in the bottle. The pediatrician, Dr. Bloom, who diagnosed the illness attributed it to the sour milk. "And why is he still drinking from a bottle? He's too old to be drinking milk

from a bottle," the doctor said. My father was very angry, and chastised my mother bitterly for "spoiling" me, in the doctor's presence. I felt humiliated and helpless in the face of the charges leveled at me. My secret oral perversion had been discovered! The secret was out! The doctor advised my parents that scarlet fever was considered a serious public health concern, and that he was bound by law to report my illness to the city health department. Several days later, the health department posted a quarantine notice on the front door of our home (1957). My private act led to unforeseeable consequences in the form of intervention by a government authority. In effect, at age three, the government had determined that I was already "potentially dangerous."

The scarlet fever incident contributed to the centrality of solitary self-experience for me. From an experience of pleasure (in drinking sour milk from the bottle), I was suddenly transformed to a state of loss and an inexplicable sense of guilt. I felt like a felon and, if you will excuse the hyperbole, "would hide when the constable approached the house." The illness ushered in transformation from a positive, pleasurable, self-absorbed state to a secret state marked by guilt and a personal blame for wrongdoing. I did not find solace for my loss. On my own, I bore both my guilt and the surprising, disturbing impact I could have on others in my immediate world and beyond: indeed, reaching out to a world beyond my imagination, in the form of governmental authorities. The illness also signaled another transformation in the direction of having to regulate painful states on my own without the support of others. Both parents were concerned with public embarrassment, rather than with the state of their child. I propose that the model scene I have constructed organized my experience as a solitary, impactful onlooker: someone whose private actions could even trigger the intervention of government authorities. It is an experience that few three-year-olds have. An emotionally porous three-year-old who is "hypersensitive to the goings-on in his environment," see *Freedman v. D.C. Dept. of Human Rights*, D.C. Superior Court, Judge Ellen Segal Huvelle (June 1996), will be affected by that experience.

This essay, and particularly the above anecdote, is a metaphorical bridge of speculation that connects mystery to mystery, the known with the unknown. That bridge is like a single plank that requires the support of others to form a firm foundation. I offer the following thought. My age upon contracting scarlet fever, which resulted from my mother's indulgence of my dependency needs—age three or three-and-a-half—is the same age my mother was when her father died of a communicable disease, influenza: in an influenza epidemic that, because of its magnitude, had evoked a vigorous public health response by government authorities nationwide. Is it possible that my "good" mother was instrumental in setting me up for serious illness? Was my mother's seeming indulgence really an expression of a strong unconscious ambivalence toward me that was a derivative of her emotional reaction to her own father's death?

Incidentally, the scarlet fever anecdote parallels themes in several plays by Henrik Ibsen. In *Ghosts* a mother provides poison to her son to enable the son's suicide in expiation of his father's sins; *An Enemy of the People* pits a truth-fanatic (who discovers that the waters of a spa town are polluted) against the town's mayor and its citizens; and in *The Master Builder* a mother, out of a perverse sense of duty, kills her twins—she contracted a fever because she could not stand the cold, but, despite the fever, she insisted on breast-feeding the twins, who died from her poisoned milk.

Note that I was the only male child in the family. Oddly, when I was a young boy, my older sister created the fiction that my middle name was "Stanley," my mother's father's name. I actually came to believe at one point in childhood that my name was "Gary Stanley Freedman."

Be that as it may.

My mother had a passionate interest in motion pictures and movie actors and, in childhood, was fond of playing with dolls. I picked up on these

interests in a way. In early adolescence I developed a fanatic attraction to the Wagner operas, and I had an interest in the craft of play writing. In high school and college I took elective courses in drama and theater. At age thirteen I staged (after a fashion), in the basement of our family home, a highly-abbreviated version (to say the least) of Wagner's four-opera Ring Cycle for the entertainment of my parents—though, in reality, my parents were uninterested, if not hostile to my effort.

My father was subject to bouts of depression and sometimes became bitter and violent toward my family, but he took no steps to change his situation, other than threatening, from time to time, to leave my mother. He was frequently morose and withdrawn. I reacted to my father throughout childhood with a range of irreconcilable emotions: idealization, sympathy, anger, and fear.

Taken as a unity, to be spelled out below, these accounts suggest that, for me, self-states and affects had to be regulated alone, by myself. In later life, I transformed my despondent state after my critical rebuff at the law firm where I had worked by drawing on the themes encapsulated in the model scenes.

In psychoanalytic treatment, analyst and patient construct model scenes to convey, in graphic and metaphoric forms, significant events and repeated occurrences in the patient's life. The information used to form model scenes can be drawn from a variety of sources, including a patient's narrative and recollections. Model scenes highlight and encapsulate experiences at any age, not only early childhood, and are representative of salient conscious and unconscious motivational themes. The concept of model scenes is broader than and includes screen memories, which Freud equated with the manifest dream content dream, in that they point toward something important that they disguise. The memory itself and its "indifferent" content are to be discarded as the analyst recovers and reconstructs the significant, concealed childhood event or fixation.

Whereas screen memories focus on reconstructing what has happened, model scenes pay equal attention to what is happening, whether it is in the analytic transference or in the person's life. For me, the model scene is based on recollections that capture my solitary self-regulation, self-restoration, and my triumph over my detractors.

MY AUTOBIOGRAPHY: SIGNIFICANT MOMENTS

The book is unusual in structure. It is drawn exclusively from published literature—it is a collection of quotations, really—with the quotes woven together to form a cohesive narrative, comparable in a sense to the structure of T.S. Eliot's "The Wasteland." A single, cohesive narrator or hero does not appear in the book. Rather, the author manipulates the quotations; the narrator hovers overhead, as it were, like a puppet master, pulling all the strings. I am represented, through my identification with various literary and historical figures, by identity elements or identity fragments, which are the quotations. The hero is a composite figure; his specific identity as the hero depends on the context of the writing. At times the hero is Freud, at other times, he is Nietzsche, or the psychoanalyst Jeffrey Masson, or the virologist Howard M. Temin. The hero is always the figure who rebels against the "The Powers that Be."

The themes of the book are numerous and diverse. The themes include anti-Semitism, the craft of writing, opera production, communicable disease, genetics, inheritance, the discovery of a secret that brings ruin on the discoverer, scientific discovery, truth seekers, critical response by peers, defiance of peers and authorities, banishment and social isolation, the absence of an empathic or supportive environment, the self-regulation of affects, the death of fathers, the intervention of government authorities into the private domain of citizens, the seductive or destructive mother, alleged corruption and cover-up, among other topics.

CRITICISM AND RESPONSE

The negative response I received upon my job termination and its aftermath was diffuse. It came from the employer, psychiatrists (doctors), and government authorities. If I were asked why I began to write my autobiography, *Significant Moments* in April 1993, four months after I had received the employer's defamatory pleadings in a legal action I had initiated against the employer, I would have said: "I had to write my autobiography."

In *Significant Moments*, "the hero" (who appears in various guises, or is represented by various identity elements) makes a discovery that results in his being pitted against "The Powers That Be." The detractors of "the hero" are mocked and exposed as mean-spirited and unprincipled. I thereby expressed my distrust of the capacity of the "majority" to discriminate the "true" from the "false" and to exercise sound judgment. I showed "The Powers That Be" to be swayed by self-interest and incapable of distinguishing scientifically backed findings from self-serving rationalizations.

There is no decent, supportive public in *Significant Moments*. "The hero" naively values the support of "The Powers that Be" at the opening of the book. He believes that they will be responsive to truth and evidence. Before the book's end, "the hero" could rightly say that the most dangerous enemy of truth and freedom amongst us is the solid majority. "The majority is never right! . . . The minority is always right!" The minority to which "the hero" refers is himself. By the end of the book, he can trust nothing but his own values, perceptions, and beliefs.

Wounded by the shortsighted managers at Akin Gump, I asserted that the creative artist stands alone, a minority of one, to maintain his integrity and the purity of his vision. In *Significant Moments* I spoke with one uncompromising, solitary voice clearly depicted in "the hero," who loses

all support and ends alone. "The strongest man in the world is the man who stands most alone." Increasing isolation drives "the hero" to proclaim, "I want to expose the evils that sooner or later must come to light."

To explore and to react aversively are dominant motivations for "the hero" of *Significant Moments*. He is uncompromising to the end, a man who does not mean to settle for rapprochement with the majority. He is ready to bring ruin upon himself and others rather than "flourish because of a lie."

In my response to the critics, I presented my hero as totally decent and honest, but naive with respect to political wheeling and dealing. His decency and goodness are contrasted with the narrow-mindedness of the majority. They are devoid of a sense of morality of their own and led by authorities who are rigid, unimaginative, self-serving, and bureaucratic—banal at best and corrupt ("poisoned") at worst.

CREATIVE TRANSFORMATION: FROM JOB TERMINATION TO SIGNIFICANT MOMENTS

The themes of *Significant Moments*, father-son tensions (real or symbolic), living a lie, the effects of learning "the truth," inheritance (in my case, the transmission of parental strengths and weaknesses), all manifestly rooted in my early life, are taken up in my book. In so doing, I addressed a compelling, burning, residual issue from my past and depicted it as a metaphor for my society as well. *Significant Moments* thus combines painful memories with a devastating social critique. Personally, I expressed my disillusionment at my father's legacy of academic, occupational, and marital failure, as well as my quest for an idealizable father of whom I could be proud.

Apparently, I felt compelled to bare myself in a barely disguised form. I gathered together my past grievances and projected them on to "The

Freud Archives Board." In them I embodied the lies, hypocrisy, deception, and duplicity that I hated in society. So long as they typified "The Powers that Be" and its "opinions," there could be no compromise. My uncompromising depiction of the "sins of the father," the "ghosts" that demand placing duty and public appearances above self-expression and individual freedom, expresses my long-held convictions in the purest, boldest form.

At the center of *Significant Moments* lies my determination to explore two sides of deception. Some self-deception is held necessary to maintain hope and to survive, yet there is also a pernicious self-deception that erodes ethics and undermines morality. In the book, the psychoanalyst, Jeffrey Masson—initially chosen as the ideal candidate to head the Freud Archives Board is later fired by the Board under dubious circumstances that betray the Board members' self-deceptions and deceptions of others. Another character is the philosopher Friedrich Nietzsche, a disciple of the composer Richard Wagner, but, later—spurned by Wagner—becomes the composer's harshest critic. The duty-bound rejection by "The Heroes" (Nietzsche and Masson) of their superiors was felt by "The Powers that Be" (Wagner and the Freud Archives Board) as both a rejection of their ideals and a personal betrayal.

I was shocked by my sudden job termination in late October 1991; but later (in April 1993), within four months of receiving the employer's defamatory pleadings in the complaint I filed, I began work on *Significant Moments*. With my self-confidence shattered, if there was a moment when the capacity to transform shattered narcissism into artistic creativity was called for, this was it. *Significant Moments* became my response to the devastating experience of my termination and its aftermath. The employer advised a government agency that it had determined that I was potentially violent—that is, a physical danger to others: an allegation that must have resonated with my memory that at age three I had been determined by a municipal authority to pose a public health risk.

In *Significant Moments* moral integrity on one side is pitted against deception, pomposity, and narrow self-interests on the other. The battle lines are drawn clearly. Perhaps in outrage, all gloves are off. I myself step upon the stage and drag my enemy, conventional wisdom, front and center with me.

The hero pays the price for his naive belief in truth; he is socially isolated, but he remains undaunted. Throughout *Significant Moments*, the hero remains loyal to the idea that truth will win the day. He utters the line (through playwright Arthur Miller) that embodies "the hero's" defiance of the "majority," and defines the state in which he feels himself to be: independent, invulnerable, and exquisitely self-contained. "The strongest man in the world is the man who stands most alone!" One section of *Significant Moments* is devoted to the case of Alfred Dreyfus, a French-Jewish army officer who, in the late 1890s, was falsely and corruptly convicted of treason and sentenced to solitary confinement. The celebrated French novelist, Émile Zola risked his career and imprisonment, and published "J'Accuse..." on the front page of a Paris daily. The controversial story was in the form of an open letter to the President of France. Zola's "J'Accuse..." accused the highest levels of the French Army—The Powers that Be—of obstruction of justice and antisemitism by having wrongfully convicted Alfred Dreyfus to life imprisonment on Devil's Island.

To me, the artist's strength lays in an undaunted capacity to maintain a vision in the face of opposition and to "cleanse and decontaminate the whole community." I must disturb, be perpetually misunderstood, and walk alone. Yet, I would call *Significant Moments* an expression of the "comedy of life" in that it expresses my recognition that the creative artist cannot totally stand alone. Ultimately, he needs an audience to respond to him.

CREATIVITY IN SELF-STATE TRANSFORMATION

The artist accepts isolation as a consequence of his superior, unique vision of the world. He depicts his ideal, to follow the dictates of his artistic integrity, irrespective of the consequences. Compromise means accommodating to societal pressures, hypocrisy, and deception.

In *Significant Moments* the tyranny of conventional wisdom, the legacy of father to son, and the strength inherent in one's solitary loyalty to the "ideal" of truth appear on an unadorned stage.

It is always risky, when discussing an artist, to draw inferences about his life from his creative output. Nonetheless, parallels do exist between the artist's life and his creative work.

Traumatic, painful, or humiliating life experiences sometimes provide the context for an artist's work. To some extent, the creative product is the transformation by the artist of the effects of his painful past and narcissistically injurious experiences. Here, transformation refers to self-regulated alterations, the capacity to alter one's self-state, when, for example, it is characterized by guilt or shame, stirred by feelings of defeat and, when exposed to contempt, derision, or ridicule. To turn painful self-states into a sense of triumph requires transforming narcissistic injuries, often though not invariably, via narcissistic rage, into a sense of having righted a wrong, avenged a slur, or seized self-"intactness" from the jaws of injury.

Significant Moments is a self-revelation. As the book proceeds headlong toward its denouement, the passages that describe the weather and the lighting are psychologically revealing. Thus, the portion of the writing that describes the high point of the Wagner-Nietzsche relationship refers to the brilliance of the sun:

The sky was cloudless and azure colored, and on the far side of the lake the mountains . . . glowed in bright sunlight.

Russell Banks, *The Reserve*.

They were seated in the boat, . . .

Ernest Hemingway, *Indian Camp*.

. . . facing each other like two mirrors, . . .

Gabriel Garcia Marquez, *One Hundred Years of Solitude*.

. . . Nietzsche . . .

Henry Adams, *The Education of Henry Adams*.

. . . in the stern, . . .

Ernest Hemingway, *Indian Camp*.

. . . Wagner . . .

Henry Adams, *The Education of Henry Adams*.

. . . rowing. The sun was coming up over the hills. A bass jumped, making a circle in the water.

Ernest Hemingway, *Indian Camp*.

Nietzsche . . .

Henry Adams, *The Education of Henry Adams*.

. . . trailed his hand in the water. It felt warm in the sharp chill of the morning. In the early morning on the lake sitting in the stern of the boat with . . .

Ernest Hemingway, *Indian Camp*.

. . . his mentor . . .

Gabriel Garcia Marquez, *One Hundred Years of Solitude*.

. . . rowing, he felt quite sure that he would never die.

Ernest Hemingway, *Indian Camp*.

While the last meeting of Wagner and Nietzsche, the end of the friendship, takes place on a cold, drizzly evening—the night of a dinner party:

Wagner was not in the best of moods, and . . .

Martin Gregor-Dellin, *Richard Wagner: His Life, His Work His*

Century.

. . . just as . . .

Henry James, *Washington Square.*

. . . the clock has struck eleven . . .

Richard Wagner, *Die Meistersinger von Nürnberg.*

. . . Nietzsche found himself being driven back . . .

Martin Gregor-Dellin, *Richard Wagner: His Life, His Work, His Century.*

. . . home . . .

Homer, *The Odyssey.*

. . . "through a drizzle" by his host and hostess.

Martin Gregor-Dellin, *Richard Wagner: His Life, His Work, His Century.*

Now they drove in silence, their lips tightly closed against the cold, occasionally exchanging a word or two, and absorbed in their own thoughts.

Boris Pasternak, *Dr. Zhivago.*

* * * *

The night swirled around him, the courtyard . . .

Alan Furst, *The World at Night.*

. . . of his Albergo . . .

Samuel Irenæus Prime, *The Irenæus Letters.*

. . . only a hundred feet away, . . .

Mary Roberts Rinehard, *Dangerous Days.*

. . . the wet cobblestone gleaming in the faint spill of light from blacked-out windows. He forced himself to look around:

Alan Furst, *The World at Night.*

The dog howls, the moon shines. Sooner would I die, die rather than tell you what my midnight heart thinks now.

Friedrich Nietzsche, *Thus Spoke Zarathustra.*

Creative writers, including myself, often depict self-states of fictional characters through, for example, reference to weather. Changes in the weather foreshadow, just as a dream of a barren countryside may reveal and foreshadow, the state of the self. The three final therapy sessions on January 22, January 29, and February 5, 2019, presented in the following pages, revolve around my recollections of a blizzard that I experienced when I was thirteen years old; perhaps my references to the blizzard relate to a particular self-state. A passage in *Significant Moments* describes a journey through a snowstorm. One thinks of the self state, conducive to creativity, of "deep, internal reverie, which like the frozen landscape, nurtures the hidden forms within."

Drove into town, home with R., . . .

Cosima Wagner's Diaries (Thursday, January 4, 1872).

. . . through . . .

Italo Calvino, If on a winter's night a traveler.

. . . fog, darkness, and snow, . . .

Cosima Wagner's Diaries (Thursday, January 4, 1872).

We both felt . . .

Charles Dickens, Bleak House.

. . . dazed, contemplating that whiteness . . .

Italo Calvino, If on a winter's night a traveler.

. . . as if each of us were hypnotized . . .

R.D. Laing, The Politics of the Family.

. . . looking fixedly at . . .

Charles Dickens, Bleak House.

. . . blank manuscript pages . . .

Patrick Kavanagh, The Spiritual Lives of the Great Composers.

. . . (themselves a rustling woods)

James Richardson, Excerpt from "Essay On Wood."

As Wagner journeyed . . .

Martin J. Bollinger, Warriors and Wizards: The Development and Defeat of Radio Controlled Glide Bombs of the Third Reich...

... through the wilderness, his mind moved in its own direction; the two trajectories, one physical, the other mental, were joined . . .

Dan Chiasson, *Paper Trail: The Material Poetry of Susan Howe*.

. . . in a metaphorical dance

Catherine Ann McMonagle, *Dancing Feminisms and Intertextuality*.

I at last . . .

Cosima Wagner's Diaries (Thursday, June 3, 1869).

. . . a blanket to my chin . . .

Robert Frost, *Excerpt from "An Unstamped Letter in Our Rural Letter Box."*

. . . thought of the times when I lived here against all the rules like a dream figure, and when this landscape seemed so appropriate.

Cosima Wagner's Diaries (Thursday, January 4, 1872).

Not till we are lost, in other words not till we have lost the world, do we begin to find ourselves, and realize where we are and the infinite extent of our relations.

Henry David Thoreau, *Walden*.

Significant Moments also contains numerous biblical allusions and quotations. In adult years I have stood alone against my critics, who have usually been stronger and more numerous than my defenders. The source of my strength—my ability to stand alone, undaunted—I believe, is ultimately a positive inheritance from my father: namely, my father's ego-strengthening identification with the historical struggle of the Jewish people for survival. My ambivalence toward my father now becomes more understandable. My "inheritance" did not only include my father's failings, but contained a substantial quantum of support from him as well. My solitary faith in myself and my eventual triumph, coupled with my memory of my father's loyalty to the best in the Jewish tradition, may have provided the strength that has enabled me to stand alone and continue my struggle without the aid or presence of another.

After my disappointing job termination in 1991, my self-state could be characterized as enraged by new disappointments, as well as the revival of the old hurts and disillusionments. I sought refuge through the transformation of my painful state to one that may also have been an enduring legacy of my childhood, a state devoid of impingements from others and free of the disappointment I felt in my father. I sought a sense of supremacy, alone and at peace. Akin to a puppeteer, I longed to be above the critics and the mundane world, without concern for social status, economics, or prestige.

The final three therapy sessions—on January 22, January 29, and February 5—form a thematic arc that expounds my recollections of and reflections on a single day from childhood, Saturday, December 24, 1966, the day after my thirteenth birthday. My hometown, Philadelphia, experienced a blizzard that day. The following discussion of these three sessions is supplemented by a concluding creative piece, an essay titled “Reflections of a Solitary on a Snowy Afternoon in January.” As noted in the previous pages, creative writers often depict self-states of fictional characters through, for example, reference to weather. Changes in the weather foreshadow, just as a dream of a barren countryside may reveal and foreshadow, the state of the self. Might a preoccupation with the unpeopled landscape of a blizzard express a dissociated state of bliss in which subjective agonies are suspended, or frozen in space and time—safely distanced from the elated sentient contemplation of one’s “solitary track stretched out upon the world.”

Therapy Session: January 22, 2019

The challenge facing the therapist is to make active attempts to turn his or her attention toward trauma-related material; to listen for it, notice it, ask about it, and facilitate rather than avoid such painful topics. If not, the risk is that of replicating the rejecting response of the parent who reacts to the child’s abuse revelations by discounting or minimizing their importance.

—Robert Muller, “*Trauma and Dismissing (Avoidant) Attachment: Intervention Strategies in Individual Psychotherapy.*”

Things that were hard to bear are sweet to remember.

—Lucius Annaeus Seneca.

The woods are lovely, dark and deep,
But I have promises to keep,
And miles to go before I sleep,

And miles to go before I sleep.

—Robert Frost, “Stopping by Woods on a Snowy Evening.”

At this session I made a determined effort to talk about important trauma issues from my childhood. I tried to refrain from intellectualizing or delving into psychoanalytic theory, as I often do. Instead of making an active attempt to turn her attention toward this trauma-material; to listen for it, notice, it, ask about it, and facilitate the trauma material, the therapist ignored the trauma-specific nature of what I talked about and instead undertook a rambling, nonresponsive and, at times, incomprehensible sermon on my failure to make use of what she had to offer, my preoccupation with psychoanalysis, and my apparent lack of interest in forming a meaningful relationship with her. Keep in mind, the therapist is clinical director of a trauma clinic and claims to be knowledgeable about trauma and trauma treatment. I am not aware of any legitimate or evidence-based trauma treatment that advocates utterly ignoring a patient’s narrative about the traumatic features of his childhood – or reacting to the patient’s abuse revelations by discounting or minimizing their importance.

The following therapy report highlights nine substantial and recognized trauma issues that merited attention by the therapist. She ignored all nine trauma issues. The trauma issues in the following therapy report comprise the following: (1) serious childhood physical injury (trauma); (2) affective reversal; (3) vertical splitting; (4) paternal depression and grief; (5) parental discord and resulting scapegoating; (6) domestic violence; (7) sibling envy; (8) intergenerational trauma and family dysfunction; and (9) narcissistic abuse.

PATIENT: So, something has been on my mind, actually for a long time. It weighs on me. You know, I was referred to the Wendt Center because it is a trauma clinic. A therapist said I needed trauma work. But, you know, you never address the trauma material that I talk about. I talk

about a lot of trauma issues and you seem to consistently deny the trauma material I talk about. I don't see how that's trauma work. Like last week, I talked about my relationship with my sister, how I felt that she was always competitive with me and envious and jealous of me. And all you said was, "Did you ever talk to your sister about your feelings about this?" Well, I don't see how you were addressing a trauma issue. I mean, why would I talk to my sister about this? That's her personality. That's the way she is with me. That's the way she's always been with me. She's not going to change because of something I say to her.

THERAPIST: I'm not saying she should change.

PATIENT: Well, I don't see how talking to her about this will have any meaning.

[Note the transference aspect of my statement, which seemed to be lost on the therapist. Was I not saying that it's useless for me to complain to the therapist about my concerns about her therapy work? Am I not saying that I feel the therapist is inflexible and that she will not modify or adapt her technique to my needs? When I talked about my sister at this session, was I not symbolically talking about my sense of futility in working with my therapist? And is that not a substantial issue that the therapist – who claims to be relational – needs to attend to? Shouldn't the therapist make active attempts to turn her attention toward transference material; to listen for it, notice it, ask about it, and facilitate rather than avoid such topics simply because the therapist views any valid criticism as a narcissistic injury?

Indeed, any evidence-based attachment technique emphasizes the importance of the patient being permitted to talk about his negative feelings about the therapist. See, e.g., Gelso, C.J., et al., "Attachment Theory as a Guide to Understanding and Working with Transference and the Real Relationship in Psychotherapy." "The attachment-oriented therapist works to help the patient understand his or her internal working

model, how it relates to the patient's early experiences, the therapist (as transference), the actual person of the therapist, and relationships with significant others in the patient's life. The aim, particularly in longer term, dynamically based treatment, is to modify working models to accommodate the realities of new experiences and new relationships, including the realities of the therapist. This can be done through exploring and working through the transferences [both positive and negative] and/or the creation of a secure base and safe haven in which the therapist, in essence, behaves contrary to the patient's problematic internal working model." How does the therapist's rejecting attitude toward my criticism of her [a reflection of my internal working model] demonstrate to me that it is safe and acceptable to raise valid concerns [or negative transference feelings] about the therapist or anyone?

Gelso describes his patient's failure to express negative feelings about him as "hidden transference" – as something that the patient needs to overcome. "At times, though, I have felt that [my patient's] transference was too hidden, as if there was a chronic transference resistance. . . . As part of this transference resistance, until recently [my patient] kept negative feelings toward me out of the work, and for several years resisted seeing me as other than an equal, a kind of wise and safe brother (the positive transference)." Gelso emphasizes that where a therapist does not permit a patient to express his fears and anger toward the therapist, the patient will be unable to rework his maladaptive internal working model.

Shouldn't my therapist have explored the apparent fact that I view her as an envious, aggressive, self-centered, and dismissive older sister—intent on preserving her status as my superior? As I have written elsewhere, I believe that because of the therapist's ego vulnerability she cannot deal with a mature relationship in which the parties accept their ambivalence toward each other, but rather needs to be worshipped and adored as if she were the pre-ambivalent, loving mother suckling her infant.]

PATIENT: So just this last week, I did some research and found that sibling envy is a valid issue in attachment work or trauma. I read an article by an attachment therapist who talked about one of his patients – the patient had an insecure attachment style like me – and the author, he's a psychology professor at the University of Maryland, he makes it clear in the article that sibling envy is an important issue in attachment. But the thing is, last week, when I talked about my sister being envious of me you totally ignored that as if it were meaningless. Here, let me read you what he writes about his patient. It sounds just like me in some ways:

*"Although Thomas and his brothers and sisters had plenty of material things, they lived in a deeply depriving home environment. No one seemed to get emotional nourishment, and the level of aggression among the children was intense. It was as if all the children were angry about what they were not getting. Thomas was often physically assaulted by two of his older brothers, who no doubt resented him for what he got from the mother. As the youngest, she often took him on excursions with her, and when he returned from these excursions, Thomas had hell to pay with two of his brothers. He recalls virtually no experiences in which anyone in the family took an interest in him, responded to him with affection, or taught him anything about the world or psychological life. He recalls truly outstanding athletic performances as a child, after which he walked home alone with a deep sense of emptiness. No one in the house ever asked him about what he had done, and **he could not initiate discussion of his accomplishments for fear that it would arouse his brothers' envy and aggression.**"* See, Gelso, C.J.

So see, this is what I'm talking about: the patient "could not initiate discussion of his accomplishments for fear that it would arouse his brothers' envy and aggression." That's exactly what I was talking about last week, and you just ignored that. Remember? I told you those anecdotes about my sister? I mentioned that when I graduated from law school my sister made snide comments about that. She seemed to ridicule me. She said, "So I was thinking about what to get you as a graduation gift. And you know what I settled on? It would be the perfect gift! Can you guess

what it is? A cake mixer!" Well, she knew I lived in an apartment that didn't even have an oven! And I don't bake cakes! She knew that. I think she was just ridiculing me out of envy. It's as if she was feminizing my accomplishment out of envy. And then I mentioned the other thing where my law professor gave me the highest grade in the class. He told me he wanted to put my exam answer on reserve in the library as the model answer that other students could read. So I told my sister about that and she gave a snide response. You see, the course was civil procedure. You can't practice civil procedure. It's not substantive law. So my sister said sarcastically, "Oh, civil procedure. Can you actually practice that?" She was making fun of my accomplishment. Well, that's envy and that's what I live with – have always lived with – with my sister. And this article says it's an important thing—sibling envy. It contributes to an insecure attachment style, which is what I have. But the thing is you totally ignored that. And it's an important issue.

THERAPIST: Why do you hold onto those anecdotes about your sister?

[One wonders whether the therapist's question was actually counter-transference. Was the therapist really asking: "Why do you hold onto these grievances about my work?"]

PATIENT: Well, you know there are two *me*'s. There's the person who experiences disturbing things. Then there's the person who observes and analyzes. I love analyzing my sister and other people. This is fodder for my analysis. I'm like a scientist doing research on a disease. So bad experiences are painful and my way of dealing with the pain is to push the pain itself off to the side and assume the stance of the observer or scientist looking at the meaning of other people's behavior. I get pumped up about analyzing other people. I think it's a way of distancing myself from the pain I experience with some people.

[What I am describing is what is termed in trauma work, vertical splitting: a traumatized person's split between an experiencing ego and an

observing ego. The fact that the therapist failed to recognize that I was in fact describing a recognized and common trauma symptom is telling. Also, telling is the fact that the therapist's question "Why do you hold onto those anecdotes about your sister" is seriously flawed. What the therapist did was to deny my affect-laden, lived experience of my sister's narcissistic abuse – her act of ridiculing me out of envy – and transforming that disturbed experience into merely a benign idea. The pertinent psychological issue here is my painful *experience* of my sister's envious aggression, not the retelling of two anecdotes in therapy. The two anecdotes I reported about my sister are prototypical of a lifetime of *experiences* in a disturbed sibling relationship. Psychologically, what is ultimately significant about the anecdotes is not the anecdotes themselves but the underlying affect-laden, lived *experience* over many years, that is, the style of my sister's disturbed relatedness to me. That affect-laden lived *experience* would be important in understanding my internal working model whether or not I recalled or "held onto" any specific ideas about my sister. I know of no legitimate or evidence-based trauma technique or attachment technique that justifies failing to examine the painful feelings associated with disturbed lived experiences.

But there is more than this. The therapist's interpretation even fails as a legitimate CBT intervention. It is recognized that cognitive reframing of a patient's *ideas* about his affect-laden experiences is worthless in cases of vertical splitting. "The vertical split shows itself phenomenologically as two parallel experiences of perceptions—both a knowing and a not-knowing of the disavowed content, that is, the affects surrounding the traumatic experience. For the disavowing patient, by definition, the usual continuity between the mental registration of something (by the observing ego) and its affective consequences (registered by the observing ego) is not to be expected. See, Giacomantonio, S.G., "Disavowal in Cognitive Therapy: The View from Self Psychology." In other words, cognitive reframing ("Why do you hold onto these ideas") is worthless in vertical splitting where the disavowed disturbed feelings of the "experiencing ego"

are split off from the conscious ideas about the experience held by the observing ego.]

PATIENT: But I want to talk about something else. I want to go back to what I talked about at our session on December 18. Yeah, Tuesday December 18. That was our last session before the holiday break. I raised important trauma issues at that session, but I had additional ideas about that. I don't think we completely explored the underlying trauma issues. So what I talked about was the events of Saturday December 24, 1966, when I was 13 years old. I had just turned 13 the day before. That's why I remember this. Anyway, what I said was that there was a huge snowstorm that day. It was a blizzard. And, you know, I looked that up to confirm and, there are things on the Internet about that storm. It's called the great Christmas Eve blizzard of 1966. That morning my parents got into a huge argument in the kitchen. My father got enraged. He started beating his fists against his head. Maybe he was foaming at the mouth. But I don't specifically recall that. But maybe he was foaming at the mouth.

THERAPIST: Do you remember why your father was so angry?

[The therapist inquires about my father's anger toward my mother but not about my affective response to that anger.]

PATIENT: My father always got depressed around the Christmas holidays. His mother died on New Year's Day in 1933 and his father had died on Christmas Eve in 1929. And I don't think he ever got over that. It was like pathological mourning. He never got over their deaths. His parents died thirty years before, but he was still caught up with that. It's like what you deal with at the Wendt Center. Loss and grief. So the holidays were always a difficult time for my father. I told you about the time my parents got into a huge argument in the kitchen when I was about ten years old, and my father tried to strangle my mother. He tried to kill her. And that happened at Christmas time. It's the same thing. My father always got depressed and aggressive during the holidays.

So, anyway, it was a Saturday, so my mother did her grocery shopping on Saturdays. So there was no food in the house. She needed to go to the supermarket. And the blizzard was already so bad that my mother couldn't drive the car to the supermarket. So she had an idea. She would take my snow sled and tie a cardboard box to the sled and haul the sled to the supermarket. Then she would fill up the cardboard box with necessary grocery items, and drag the sled back home with the groceries. So she had my sister go with her to the supermarket. My sister was nineteen years old at the time. So they went off. My father had gone to my parents' bedroom, I think. He had a radio in the bedroom and he would listen to the radio there. So while my mother and sister were out, my aunt called. My mother's older sister. She wanted to speak to my mother. I told my aunt that my mother and sister went to the supermarket. And my aunt was furious. She wanted to know why I didn't go to the supermarket with my mother in the blizzard instead of my sister. I explained that I had just taken a shower and my mother didn't want me to get a chill. So my aunt really lashed out at me.

Then around six o'clock we had dinner. And my mother said that she had ordered a birthday cake for me at the Gimbel's Department store at the mall, which was about two miles away. [My thirteenth birthday had been the previous day.] She told me she wanted me to go with her to the Gimbel's because she didn't want to lose the deposit she had put down on the cake. So at about 6:30 PM my mother and I trudged off in the blizzard to the mall. And, you know, the storm was even worse now than it had been earlier. And there were really bad winds. Every footstep was a chore in the deep snow. We were concerned the whole time about getting to Gimbel's before it closed. It closed at 9:00 PM and if we didn't make it on time, the whole trip would have been in vain. I couldn't see how we could get there if every single step took so much work. It normally takes about a half hour to walk to the mall. But in the storm it took us about two hours. And we got to Gimbel's at around 8:30. As I say, the store closed at 9 PM. It was such a relief when we got there. The

store was still open. And there was a bus that stopped at Gimbel's door. So we took that bus to go back home.

So in some ways it was really an unpleasant day, what with my parents arguing and my aunt attacking me on the telephone. But, you know, here's the part that's really weird. I actually have nostalgic memories of that day. Memories of that day always flood back at Christmas time. And, you know, I sometimes think that if somebody could magically allow me to relive one day in my life, it would be that day. It's kind of crazy, because, as I say, it was an unpleasant day. So why would I be nostalgic about that day? Seems kind of crazy.

So that's what I talked about at our session on December 18.

Then in just the last few days I made a connection with an earlier event. It was on January 20, 1961. I was 7 years old. And I can remember that day because it's the anniversary of President Kennedy's inauguration. And there was a blizzard on that day too. And I looked it up and it's called the Inauguration Day blizzard that affected the east coast. I woke up that morning and I had a few blisters. I showed my mother and she said it looked like chicken pox. So my mother called the pediatrician and he told my mother to bring me into the office. The doctor's office was in his house, so he was in the office that day despite the storm. My father was home that day from work. I'm guessing his place of work was closed because of the storm. And I remember him watching the inauguration on TV. So I guess I was too sick to walk in the storm and my mother had an idea. She bundled me up and had me sit on my snow sled and she carted me off to the doctor's office. His office was just about five blocks away. It's just like what happened when I was thirteen: the blizzard and my mother using the snow sled. The thing is that chicken pox is a viral infection. You can't treat it with antibiotics. So I have no idea why the doctor wanted my mother to bring me into the office.

[At a later point in the session I talked about this event as it related to the disturbed dynamics between my parents:] So, in later years, my mother always used this incident to berate my father. She would always say, "You never loved him the way I loved him. I took him to the doctor's office in a blizzard. You wouldn't do that. You stayed home. But I did that! I took him to the doctor's office in a blizzard.

[The therapist did not comment on this event.]

So, here's the thing. There's this idea called screen memories. Did you ever hear about that?

THERAPIST: Yes.

That's what I'm thinking that these two events are related to each other. The thing is that neither of these events is really traumatic. But they may be a screen for that injury I told you about when I was two-and-a-half years old. I had a serious injury in my mouth in the summer of 1956, when I was two-and-a-half. My mother was cleaning the kitchen, and washing the kitchen curtains, and she placed the curtain rods on the kitchen table. She was on the telephone ignoring me. I picked up one of the curtain rods, I'm guessing to get her attention because I didn't like the fact that she was ignoring me. I put the curtain rod in my mouth and I fell. The curtain rod punctured the soft palate in the roof of the back of my mouth. And my mother told me that there was a lot of bleeding. She said she was afraid I would bleed to death. And I'm guessing that is part of why this was traumatic for me is that I internalized my mother's panic. She contacted the doctor – the same doctor who treated my chicken pox – and he was on vacation. And that confirms that it happened in the summer to some extent; the fact that the doctor was on vacation. I was two-and-a-half in the summer of 1956. Of course, I don't remember any of this. But my mother would tell me this story from time to time. And that tells you that it was important to her, because why did my mother keep telling me about this even years later? The doctor was on vacation.

And he had referred his patients to a young doctor named Dr. Shley. I don't remember him at all. Maybe I saw Dr. Schley only once. So I don't know what my mother did with my sister. My sister would have been 8 years old. And if this was summer, my sister would have been home from school. Maybe my mother left my sister off with a neighbor. I don't know. I have no idea how my mother got me to the doctor's office. My parents didn't own a car. They didn't drive. Maybe my mother took a cab. I don't know. Is it possible my mother was in a panicked state the entire time on the way to the doctor's office? I have no idea. So the doctor had to cauterize the wound. That's what my mother said. So it must have been serious if the doctor had to cauterize the wound. And I guess that was painful for me in itself because when you cauterize a wound it burns the skin.

So, I'm thinking that's definitely traumatic in a real sense. The chickenpox incident when I was seven and my thirteenth birthday weren't really traumatic in a real sense. But the curtain rod incident was definitely traumatic. And I'm thinking that my feelings of nostalgia about my thirteenth birthday and the chicken pox incident from age 7 are screen memories for the earlier traumatic event from age two. And I'm thinking that that's where my nostalgic feelings come in. I'm curious about the possibility that in a screen memory there can be affective reversal. So the traumatic event was painful and disturbing, a later memory screens out the memory of the earlier events but also screens out the mental pain by transforming the pain into nostalgia. And I did some research on that and I found that that can be true. For example, I was reading about aging Holocaust survivors. It's been found that some of them actually develop nostalgic feelings about their concentration camp experience. Well, of course, there's something going on there because the concentration camp experience was a painful experience. And I was reading about this phenomenon called "affective reversal." The later nostalgic feelings reverse the pain of the earlier traumatic experience.

THERAPIST: I think that what you'll find is that for many Holocaust survivors, the camps were the last time they saw their relatives, so they have nostalgic feelings for their lost relatives.

PATIENT: Well, that's true too. But what I'm saying is that there's actually a process called affective reversal where the nostalgic feelings the survivors have can be a defense against trauma and not necessarily only a reaction to the loss of their relatives. The nostalgic feelings can be a defense against trauma.

[In point of fact, camp survivor and Nobel Prize winning author, Imre Kertesz wrote about his nostalgia for the time he spent in the camps – not about nostalgia for lost relatives. See, Scanlon, A. "Imre Kertesz, *Fateless* and His Holocaust Nostalgia." See also, Aleksandar Stevic, "Intimations of the Holocaust from the Recollections of Early Childhood: Childhood Memories and the Uses of Nostalgia in Danilo Kiš and Christa Wolf."

See also, Anonymous, "Can one have a nostalgic feeling for a time of great suffering?" The author writes: "Something I have noticed in my life is that no matter how terrible a period is that I've gone through, I always end up feeling at least a little pang of nostalgia for it after enough time has passed. I remember the holiday season of 1997 when I was at one of my life's lowest points (homeless, penniless, optionless) and I remember thinking even then that I should try to record the moment in my memory to revisit specifically years later to see if that horrible period would still appear gauzy and warm in retrospect and, oddly enough, it did.]

[At this point the session broke down. The therapist proceeded to hijack the session after my expansive trauma report to talk exclusively, for the remainder of the session, about my failure to allow her to help me; my misplaced desire for psychoanalysis (in fact, I only spoke of trauma at this session, not a desire for psychoanalysis); and my lack of interest in developing a relationship with the therapist (blatantly false—I want to talk

about my transference feelings for the therapist both positive and negative, but the therapist seems to permit only worshipful adoration).

I had the sense that the therapist felt deeply put off by my act of repudiating what amounted to her attempt to reframe the concentration camp survivors' experience. She seemed to want to emphasize the idea of "separation anxiety" as it related to the survivors (that is, the survivors' loss of their relatives) and reject the idea that the camp survivors' nostalgic memories were a defense against the specific psychic pain of trauma. I sense that the therapist felt stung by my rejection of her ideas, which aroused a deep sense of futility in her about working with me.

The therapist and I seem to have radically different views about therapy. She emphasizes the emotionally corrective nature of therapy and seems to require that the patient imbibe her feedback, that is, internalize her *outlook*. My view of therapy centers on the importance of both the real relation with the therapist in addition to the fantasy elements in my relationship with her. For me, the value of therapy lies in the therapist's promoting the patient's own *insight*, rather than simply providing an *outlook* that the patient must internalize.

Insight involves the patient's seeing and engaging with intrapsychic conflict; it is part of the *journey* of therapy. Many psychic healers seek to obviate the *journey* and the conflict by promising salvation through caring and love – the emotionally corrective experience – which is what they and their patients feel the patients lacked. But false promise fosters brainwashing. See, Shengold, L. *Soul Murder: The Effects of Childhood Abuse and Deprivation*.

At this session, I wanted to describe my feelings of psychic pain aroused by childhood trauma and my defenses against that pain (such as the affective reversal of trauma); the therapist wanted to turn away from the specific psychic pain of trauma, deny the defensive nature of my nostalgic

feelings, and focus only on what she sees as my sense of hurt about not being loved and nurtured in childhood. She viewed my feelings of nostalgia not as a defense against trauma but rather a longing for the limited love that I did receive.

The therapist's trauma-distorting schema – that the traumatized child is struggling only with a need for love and security rather than additionally struggling with the specific sequelae of traumatic experience – dominated her ensuing comments about my therapy relationship with her. In her mind, my dissatisfaction with her grows out of my own failure to develop an emotionally satisfying relationship with her and thereby derive the positive therapeutic benefits that I would thus accrue. In fact, my dissatisfaction with the therapist at this session centered on her inability or failure to explore the specifically traumatic aspects of my childhood experiences as well as her failure to promote my *insight* about these issues.

The therapist's failure to address the numerous trauma issues I raised at the session amounted to her discounting or minimizing their importance.

Let us review in detail the substantial trauma issues I raised at this therapy session:

1. The Therapist Ignored the Psychological Aspects of Childhood Physical Trauma and Its Possible Effect on my Attachment System

CLINICAL REPORT: I had a serious injury in my mouth in the summer of 1956, when I was two-and-a-half. My mother was cleaning the kitchen, and washing the kitchen curtains, and she placed the curtain rods on the kitchen table. She was on the telephone ignoring me. I picked up one of the curtain rods, I'm guessing to get her attention because I didn't like the fact that she was ignoring me. I put the curtain rod in my mouth and I fell. The curtain rod punctured the soft palate in the roof of the back of my mouth. And my mother told me that there was a lot of bleeding. She said she was afraid I would bleed to death. And I'm

guessing that is part of why this was traumatic for me is that I internalized my mother's panic.

(The following observations are drawn from “Event Trauma in Early Childhood: Symptoms, Assessment, Intervention” by Coates, S. and Gaensbauer, T.J.)

A childhood traumatic event is an inherently frightening one that threatens the life or bodily integrity of the child experiencing it. Traumatic events can have life-shaping consequences for children, and most especially for very young children such as toddlers. Young children have essentially similar reactions to traumatic events as do adults, including posttraumatic stress disorder (PTSD), anxiety disorders, and depression, but research shows that PTSD symptoms in young children may be more unremitting than in adults. In addition, several studies have demonstrated that traumatic stress in childhood are risk factors for PTSD in adulthood. As in adults, the severity of the traumatic effects in children is generally relative to the intensity of the traumatic event. Yet there are notable differences in how a traumatic event impacts a toddler or preschooler. These differences include the young child’s cognitive immaturity, developmental vulnerability, and dependence on caregivers:

- (1) The lack of a developed capacity to form and retain verbally mediated memories can make it especially difficult for the child to develop a coherent memory of the trauma, let alone a narrative, and can also lead to unusual generalizations of fears to diverse stimuli that serve as “reminders.” There is growing evidence that young children can also encode memories in more explicit forms, such that at later developmental stages, after language capacity has accrued, they can sometimes demonstrate fragmented memories, such as through behavioral action or symbolic play. A level of complexity is added when one considers that severe traumatic events have been postulated, at least in adults, to be capable of bypassing ordinary systems of memory processing, leading to

the formation of “traumatic memories” subserved by distinct neurophysiologic systems. Such “traumatic memories” clearly occur in children.

(2) The second great difference in the way young children react to traumatic events, reflected in the diverse symptoms that can follow afterward, is the vulnerability of the young child to developmental derailment. When dealing with a toddler younger than 4 years of age, we have a human being whose neurophysiologic regulatory systems, including the stress-management system, are still in the process of formation and stabilization and whose development in general remains inextricably intertwined with, and dependent upon, the care-taking system. A traumatic event not only initiates complex and overwhelming emergency responses internally but can also shatter the child’s sense of safety and security with attachment figures—thus removing the scaffolding upon which developmental progression depends. The impact on the psychosocial environment may be as derailing as the impact on the child’s trust in his own neurophysiologic self-regulation—daily routines may be disrupted, one or another caretaker may be blamed for allowing the traumatic event, a sense of threat may linger owing not only to the child’s fearfulness but also that of the parents, and so on. Also, a traumatic event may intersect with the ongoing life of the family.

(3) The third way in which trauma in young children differs from that in older children and adults has to do with the nature of the traumatic event itself in the context of the young child’s dependency on care-givers. Children absolutely rely on their care-takers to keep them safe—the whole evolution of the system of attachment behavior (“the attachment system”) is geared to make the child continually cognizant of this necessity—and what threatens the caretaker, or makes the caretaker unavailable, threatens the child, even if there is no direct threat to the child individually. As Schechter and Tsoyali opine, a preschooler who witnesses

his mother's panicked shrieks may well feel that he is hearing his own death knell, even when there is no tangible threat to self.

Additionally, one study found an association between childhood trauma and rejection sensitivity in adolescents. Erozkan, A. "The Childhood Trauma and Late Adolescent Rejection Sensitivity."

2. The Therapist Ignored Evidence of Affective Reversal in the Therapy Report – Affective Reversal and the Attachment System

CLINICAL REPORT: But you know, here's the part that's really weird. I actually have nostalgic memories of that day [my thirteenth birthday]. Memories of that day always flood back at Christmas time. And you know, I sometimes think that if somebody could magically allow me to relive one day in my life, it would be that day. It's kind of crazy, because, as I say, it was an unpleasant day. So why would I be nostalgic about that day. Seems kind of crazy.

It has been recognized that "nostalgia may represent either a defensive regression to the past or a progressive striving for wholeness through re-connecting with what has been lost in the service of a greater integration." Pourtova, E. "Nostalgia and Lost Identity."

Let us examine more closely the view of nostalgia as a defensive denial or defensive regression to the past:

Harold P. Blum has proposed that poignant adult memories can serve as a defense against severe childhood trauma and associated unconscious conflicts. In such individuals the conscious retrieved and re-created past masks underlying trauma; the early trauma is temporally displaced, and there is *affective reversal* of life-threatening traumatic experience. Blum, H.P. "The Creative Transformation of Trauma: Marcel Proust's In Search of Lost Time."

Neurologist Alan R. Hirsch points out that nostalgia can mediate a wish to re-create an abusive past: “the nostalgic urge to recreate the past explains why so many abused children marry abusive spouses, and children of alcoholics marry alcoholic spouses — not because their childhood was happy, but rather because they seek to recreate their idealized sanitized memories of their childhood by identifying with symbolic manifestations of the past which they find in their alcoholic or abusive spouses.” “Nostalgia: a Neuropsychiatric Understanding.” Hirsch sees nostalgia as a container for idealized sanitized memories (that is, *unrealistic* memories), not as a *realistic* representation of positive or emotionally-satisfying aspects of childhood.

In my case adult feelings of nostalgia seem related to my tendency to retreat into solipsistic fantasy — an abstracted world of music and literature that doesn’t involve feelings centering on past satisfying connections with others. My feelings of nostalgia are a deeply idealized state, an otherworldly condition, removed from pain and sorrow. My feelings of nostalgia for the time of my thirteenth birthday that I described in my therapy report center concretely on my immersion in the classical music records my mother purchased for me at that time and the deeply emblematic idea of the *epic journey* (the trek through the blizzard with my mother), which Shengold associates symbolically with traversing one’s mental interior as in psychoanalysis: “the narcissistic elation that comes from self-understanding.” See, e.g., Shengold, L. “The Metaphor of the Journey in ‘The Interpretation of Dreams’.” It is an omnipotent or manic state of triumph over human connectedness rather than the imagining of past social pleasures. A knowledgeable trauma therapist will be familiar with the plight of the creative and sensitive child who finds himself in a disturbed family environment — his “attempt at preserving an inner life in chaotic surroundings.”

The concept of *affective reversal* has a parallel in attachment theory. Avoidant attachment strategies can become reliant on distortions of

cognition, which result in idealization of caregivers who may not have been ideal. With increasing distortions of cognition, there is also an inhibition of negative affect – particularly anger and fear, and an emphasis on false positive affect. For example, a client talking about some traumatic event in therapy may laugh, even though the event has been distressing. Blum's conceptualization of *affective reversal* as a defense against trauma parallels attachment theorists' recognition that childhood attachment trauma can be susceptible to defensive idealization. Purnell, C., "Childhood trauma and adult attachment."

Additionally, attachment theorists recognize that dismissing a trauma through defensive strategies such as nostalgia or idealization serves a self-protective function of splitting off the truth about a historically dangerous event from conscious awareness, so that the person describing the trauma does not acknowledge any bad feelings that are associated with it (as in vertical splitting). For clients who have developed a dismissive avoidant attachment strategy, dismissing past trauma will serve to avoid the arousal of negative affect that they have learned not to express. Purnell, C., "Childhood trauma and adult attachment."

Attachment theorists recognize that traumas may also be dismissed by blocking them from conscious memory. There are particular difficulties associated with working psychotherapeutically with blocked trauma because of the danger of encouraging false memory, and also because blocked trauma may indicate dissociation, which would require a different therapeutic response.

My therapist's interpretation that my feelings of nostalgia about the events of my thirteenth birthday do not reflect a defense against trauma, but rather the adult expression of feelings of longing about emotionally-rewarding experiences from childhood may actually be an attempt by the therapist to instill a false memory, which would be a therapeutically

deleterious maneuver that cannot represent attachment therapy best practices. See, Purnell, C., "Childhood trauma and adult attachment."

There is no justification – in either psychoanalysis or attachment theory – for my therapist's confabulation that denies the possible defensive nature of some Holocaust survivors' nostalgic memories, and that attributes those nostalgic memories only to a longing for past satisfying relationships.

3. The Therapist Ignored Evidence of Vertical Splitting in the Therapy Report.

CLINICAL REPORT: Well, you know there are two me's. There's the person who experiences disturbing things. Then there's the person who observes and analyzes. I love analyzing my sister and other people. This is fodder for my analysis. I'm like a scientist doing research on a disease. So bad experiences are painful and my way of dealing with the pain is to push the pain itself off to the side and assume the stance of the observer or scientist looking at the meaning of other people's behavior. I get pumped up about analyzing other people. I think it's a way of distancing myself from the pain I experience with some people.

Vertical splitting is a form of dissociation. Material unacceptable to the ego is pushed laterally across a vertical barrier into a dissociated compartment of the ego. It is never lost to the ego as a whole, and is never repressed into the unconscious. It must be kept in mind that dissociation is a descriptive and phenomenological term in the DSM. The dissociative disorder section is not based on a theoretical defense mechanism. The DSM meaning of dissociation is as scientific, observable and testable as any other term in the DSM system. Dissociation is an observed phenomenon and a reported symptom. It is not a theory or a personal belief. Ross, C.A. "The Trauma Model: A Solution to the Problem of Comorbidity in Psychiatry."

Psychoanalysts refer to vertical splitting as a split between an observing ego and an experiencing ego. The experiencing ego contains the psychic pain of the traumatic experience, while the rational observing ego is the knowing part of the ego that houses the historical events of the trauma.
Shengold, L., *Soul Murder: The Effects of Childhood Abuse and Deprivation*.

Attachment theorists recognize vertical splitting. As I noted above, “dismissing a trauma through defensive strategies such as nostalgia or idealization serves a self-protective function of splitting off the truth about a historically dangerous event from conscious awareness, so that the person describing the trauma does not acknowledge any bad feelings that are associated with it. For clients who have developed a dismissive avoidant attachment strategy, dismissing past trauma will serve to avoid the arousal of negative affect that they have learned not to express.

Purnell, C., “Childhood trauma and adult attachment.”

Attachment theorists recognize that it is the “negative affect” associated with the trauma that is psychologically important – not as the therapist would have it, “the holding onto anecdotes about the trauma.” Compare the therapist’s intervention: “Why do you hold onto those anecdotes about your sister?” The therapist’s intervention has no basis in attachment theory.

4. The Therapist Ignored the Importance of Paternal Depression and its Possible Effect on my Attachment System.

CLINICAL REPORT: My father always got depressed around the Christmas holidays. . . So the holidays were always a difficult time for my father. . . My father always got depressed and aggressive during the holidays.

Depression in fathers can have a detrimental impact on their child’s behavior, and social and emotional development, in addition to and uniquely compared with depression in mothers. Depressed fathers are less

likely to participate in physical play with their young children, an activity purported to assist children with their regulation of behaviors. Fletcher, R.J., "The Effects of Early Paternal Depression on Children's Development."

At a previous session I reported to the therapist that my 6-year-old sister witnessed my father beat me when I was an infant. One wonders whether my father beating me when I was an infant was related to depression.

Paternal depression negatively impacts child development. This impact is observable when paternal depression is present in the antenatal and postnatal stages and during offspring adolescence. The strength of this association is strongly reliant upon a number of contextual mediators, namely, paternal negative expressiveness, hostility and involvement and *marital conflict*. Sweeney, S. "The Effects of Paternal Depression on Child and Adolescent Outcomes: A Systematic Review (emphasis added.)"

Though the therapist is aware that my father used to beat me in early childhood, she failed to link up those beatings with my report of paternal depression in this therapy session. Were my father's beatings related to his possible depression?

Psychological testing indicated that my father's beatings might have had a decisive impact of my personality development. My psychological test report includes the following observations. "Mr. Freedman described a difficult and traumatic childhood. Mr. Freedman's father was physically abusive toward him beginning at an early age. Mr. Freedman's father was also physically abusive towards Mr. Freedman's mother, attempting to strangle her to death at one time during Mr. Freedman's childhood. Mr. Freedman described poor, abusive backgrounds of his mother as well. Mr. Freedman reported that he felt more intense anger at his mother for not protecting him from his father's abuse, as opposed to conscious anger at his father."

The test report highlights issues of trauma, confusion, the witnessing of abuse, domestic violence, intergenerational transmission of trauma, anger at mother relating to lack of maternal protection.

My MMPI two-code score (4/6) is consistent with childhood beatings. "Typically, [in test subjects with a high 4/6 profile] the parental expectations or rules were enforced quite literally, without consideration or flexibility regarding the needs and distresses of the child. Parental (or other family members') tempers are apt to have been intensely threatening and frightening to the person as a small child. The parents were experienced as punitive and coercive of the child's will and indifferent to the child's distress, and punishments were often severe."

5. The Therapist Ignored the Issue of Paternal Grief and its Possible Effect on my Attachment System.

CLINICAL REPORT: [My father's] mother died on New Year's day in 1933 and his father had died on New Year's Eve in 1929. And I don't think he ever got over that. It was like pathological mourning. He never got over their deaths. His parents died thirty years before, but he was still caught up with that.

Unresolved parental grief can affect a father's ability to form an attachment with a child. Some fathers struggling with unresolved grief express the feeling that their child does not belong to them completely, but were just on loan. Some fathers feel a coolness toward the child. Cf. O'Leary, J. "Grief and its Impact on Prenatal Attachment in the Subsequent Pregnancy." Again, at an earlier session, I reported that my six-year-old sister witnessed my father beat me when I was an infant. Was my father's unusual behavior in some way related to unresolved paternal grief?

It is also useful to think about the concept of the so-called "replacement child." A replacement child in a literal sense is one conceived to take the

place of a deceased sibling. Anisfeld believes the concept may be extended to many other situations in which a child is put in the place of someone else in the family system. The replacement child fills the void in the lives not only of individual parents but of the family as a whole. Cf. Anisfeld. Was I assigned by my father the role of replacement child for his parents? Volkan introduced the concept of deposit representations, a form of projective identification. In Volkan's words, "This concept refers to a type of intergenerational transmission where a parent or other important individuals deposits into a child's developing self-representation a preformed self- or object representation that comes from the older individual's mind." A precondition for the development of the intrapsychic structures characteristic of the replacement child, according to Volkan, is "the permeability between the psychic boundaries of the very young child and his parents, which allows the 'various psychic contents' to pass from one to the other's self-representation." Anisfeld, L. "The Replacement Child. Variations on a Theme in History and Psychoanalysis."

It is important to keep in mind that I was born on December 23 – the anniversary of the deaths of both my father's parents. One wonders how my birth on this anniversary meshed with his grief about his parents, which always seemed to emerge at this time of year.

6. The Therapist Ignored My Report of Parental Discord (which Is Related to Scapegoating of a Child) and its Possible Effect on my Attachment System

CLINICAL REPORT: That morning [December 24, 1966, when I was thirteen] my parents got into a huge argument in the kitchen. My father got enraged. He started beating his fists against his head. Maybe he was foaming at the mouth. But I don't specifically recall that. But maybe he was foaming at the mouth. . . . I told you about the time my parents got into a huge argument in the

kitchen when I was about 10 years old, and my father tried to strangle my mother. He tried to kill her. And that happened at Christmas time.

CLINICAL REPORT: *So in later years, my mother always used this incident to berate my father. She would always say, "You never loved him the way I loved him. I took him to the doctor's office in a blizzard. You wouldn't do that. You stayed home. But I did that! I took him to the doctor's office in a blizzard.*

Research shows that parental discord is associated with scapegoating of a child. Family scapegoating is essentially a form of triangulation in which parents with a high level of discord draw one child into the parental dyad as a diversion. Vogel E.F. and Bell N.W., “The Emotionally Disturbed Child as the Family Scapegoat.”

The parents end up arguing about the scapegoated child instead of directly expressing their discontent with each other. A high level of marital discord is projected onto the scapegoated child who is forced to “own” the projections in order to return the spousal subsystem to a calmer level. See Everett, C.A., Volgy, S.S. “Borderline Disorders: Family Assessment and Treatment.” (One wonders, incidentally, about the possible extent to which my problems in the workplace might relate back to conflicts between supervisory or management personnel.)

Parental discord may affect the child’s attachment system. Individuals who witnessed more verbal conflict between their parents growing up exhibited more attachment anxiety. Perceptions of less overall marital satisfaction, more frequent, and to a lesser extent, less resolved parental conflict, all related to higher reports of individuals’ attachment anxiety. Attachment anxiety, typically manifested in worries about abandonment and not being adequately loved or cared for, seem to increase as a number of variables of parental conflict increase. Chapman, B.P. “Perception of Parental Conflict as a Predictor of Attachment and Caregiving Styles in the Romantic Relationships of Young Adults.”

7. The Therapist Ignored my Report of Witnessing Domestic Violence and Its Effect on My Attachment System

CLINICAL REPORT: *My father got enraged. He started beating his fists against his head. Maybe he was foaming at the mouth. But I don't specifically recall that. But maybe he was foaming at the mouth. . . . I told you about the time my parents got into a huge argument in the kitchen when I was about 10 years old, and my father tried to strangle my mother. He tried to kill her.*

The Adverse Childhood Experiences study (ACE) found that children who were exposed to domestic violence and other forms of abuse had a higher risk of developing mental and physical health problems. Because of the awareness of domestic violence that some children have to face, it also generally impacts how the child develops emotionally, socially, behaviorally as well as cognitively.

Some emotional and behavioral problems that can result due to domestic violence include increased aggressiveness, anxiety, *and changes in how a child socializes with friends, family, and authorities.* Depression, emotional insecurity, and mental health disorders can follow due to traumatic experiences.

Additionally, in some cases the abuser will purposely abuse the mother in front of the child to cause a ripple effect, hurting two victims simultaneously. It has been found that children who witness mother-assault are more likely to exhibit symptoms of post-traumatic stress.

9. The Therapist Ignored my Report of Sibling Envy and Seemed to Discount its Effect on my Attachment System

CLINICAL REPORT: *I mentioned that when I graduated from law school my sister made snide comments about that. She seemed to ridicule me. She said, "So I was thinking about what to get you as a graduation gift. And you know what I*

settled on? It would be the perfect gift! Can you guess what it is? A cake mixer!" Well, she knew I lived in an apartment that didn't even have an oven! And I don't bake cakes! She knew that. I think she was just ridiculing me out of envy. . . . And then I mentioned the other thing where my law professor gave me the highest grade in the class. He told me he wanted to put my exam answer on reserve in the library as the model answer that other students could read. So I told my sister about that and she gave a side response. See, the course was civil procedure. You can't practice civil procedure. It's not substantive law. So my sister said sarcastically, "Oh, civil procedure. Can you actually practice that?" She was making fun of my accomplishment. Well, that's envy and that's what I live with – have always lived with – with my sister.

Attachment therapists recognize the importance of sibling envy in the formation of disturbed self-concept and maladaptive internal working models. Gelso reports the case of a patient who “could not initiate discussion of his accomplishments for fear that it would arouse his brothers’ envy and aggression.” The patient suffered from “the classic indicators of profound narcissistic injury, e.g., deeply damaged self-esteem and its flip side, grandiosity, as well as a chronic sense of emptiness.” The patient’s internal working model “[was] that others are dangerous and would despise him if they knew him deeply.” Gelso, C.J., et al. “Attachment Theory as a Guide to Understanding and Working With Transference and the Real Relationship in Psychotherapy.”

The attachment-oriented therapist works to help the patient understand his or her internal working model, how it relates to the patient’s early experiences, the therapist (as transference), the actual person of the therapist, and relationships with significant others in the patient’s life. My therapist makes no effort to help me understand my internal working model, how it relates to my early experiences, the therapist as transference figure, the actual person of the therapist, or others in my life. When I talked at this session about my sister’s envy of me, the therapist simply asked: “Why do you hold onto those anecdotes about your sister?” The

therapist might well have said, “You need to forget about how you think your sister victimized you.”

Like Gelso’s patient, I carry within the sense that others are dangerous and would despise me if they knew me deeply. These feelings arise in my relationship with my therapist. I fear her envious retaliation at those times I sense that my intellectual abilities have injured her narcissistic integrity. *Indeed, it was at the very point at this session when I used the term “affective reversal” that the therapist effectively shut down the session, hijacking the remaining time to talk about my failings in therapy.* It was as if she were saying, “I had to listen to your crap for the last half hour. Now you’re going to listen to me. Just keep your mouth shut and listen.”

At a previous session I reported that I feel comfortable with people who are smarter than me; I feel secure in their presence knowing that they will not retaliate against me out of envy. I felt unusually safe with one of my previous psychiatrists, Stanley R. Palombo, M.D.; he was a Phi Beta Kappa Harvard graduate, majoring in biochemistry. My friend Craig Dye had a near perfect score on the law school admission test; he was admitted to top law schools, including Harvard and Yale. I had a childhood friend who was a National Merit Scholar and a friend in my twenties whose brother was a National Merit Scholar and a Harvard graduate. These are the people I feel comfortable with.

10. The Therapist Ignored Issues of Family Dysfunction and Intergenerational Trauma Implicit in my Report and its Possible Effect on my Attachment System.

CLINICAL REPORT: I told my aunt that my mother and sister went to the supermarket. And my aunt was furious. She wanted to know why I didn’t go to the supermarket in the blizzard instead of my sister. . . . So my aunt really lashed out at me.

My therapist is familiar with my family background. My family was dysfunctional in that in important but subtle ways the locus of power was not in my parents but in my mother's older sister, my aunt. My aunt was a tyrannical woman; my parents were weak and dependent individuals with a poor level of autonomy. Both my parents had never separated psychologically from their families of origin; my father's pathological mourning of his parents is consistent with this. My mother was profoundly dependent on her older sister for emotional support. In important ways my aunt infantilized my mother, often going to the bathroom with her. Both my parents acquiesced in my aunt's arrogation of a parental role. My aunt was married, but childless.

My maternal grandmother was a paranoid and dysfunctional individual who was intensely and obsessively anti-Semitic. She emigrated from Poland at age 18 but never learned more than rudimentary English. In my mother's family of origin there was severe role reversal, with my aunt having to assume a parental role in early childhood to compensate for my grandmother's inadequacy. My mother's family of origin struggled with extreme poverty in the days before social welfare programs: mother reported that there were many days when there was nothing to eat but rice boiled in milk.

My aunt's act of berating me on Christmas Eve (when I was thirteen years old) because I did not accompany my mother to the supermarket in a blizzard is apparently related to issues of intergenerational trauma in which, from an early age, my aunt had to take on a parental (parentified) role of caretaker for her younger sister, my mother. My aunt frequently attempted to assign to me the parentified role of my mother's guardian or caretaker, a role that had been foisted on her in childhood. In failing to accompany my mother to the supermarket during the blizzard I was failing to adopt the role assignment my aunt had designated for me.

My family featured intergenerational enmeshment; my parents displayed continuing high loyalties to their respective families of origin with

resultant lack of personal individuation and separation; there was rigid triangulation involving my sister and me – I was the scapegoat (“bad child”) while my sister was the object of idealized projections (“the good child”); splitting and projection pervaded the parent-child subsystem; the projective identification process within the family system operated in concert with that of splitting to form rigid role assignments and expectations among specific family members. Everett, C.A., Volgy, S.S. “Borderline Disorders: Family Assessment and Treatment.”

11. The Therapist Ignored the Issue of Narcissistic Abuse Implicit in my Report and Its Effect on my Attachment System

CLINICAL REPORT: I told my aunt that my mother and sister went to the supermarket. And my aunt was furious. She wanted to know why I didn't go to the supermarket in the blizzard instead of my sister. . . . So my aunt really lashed out at me.

My dysfunctional family featured narcissistic abuse. Parental narcissistic abuse is where parents or parental figures require the child to give up their own wants and feelings in order to serve the parent's needs.

Children growing up in a dysfunctional family are believed to adopt or be assigned one or more of six basic roles that will include a scapegoated child, hero child, and a so-called lost child among three additional roles. There is abundant evidence that in my family I was assigned two roles: scapegoat and lost child. The Lost Child or Passive Child is the inconspicuous, introverted, quiet one, whose needs are usually ignored or hidden. The scapegoat, Problem Child, Rebel, or Truth Teller is the child who develops emotional problems as a diversion from parental discord. There is also abundant evidence that my aunt was the Golden Child (also known as the Hero), a child who becomes a high achiever or family caretaker or guardian as a means of escaping the dysfunctional family environment, currying favor with family members, or shielding themselves

from criticism by family members. In her role as my mother's caretaker my aunt assumed the recognized dysfunctional role of "guard dog" for my mother: a family member who blindly attacks other family members perceived as causing the slightest upset to their esteemed spouse, sibling, partner, or child.

The portion of the therapy report that focuses on my aunt berating me for not accompanying my mother to the supermarket in a blizzard at the time of my thirteenth birthday may relate to my aunt acting out the role of my mother's guardian or caretaker, and placing me in the role of scapegoat whose role it was to serve my mother's needs. (Months earlier, when I was twelve years old, my aunt had me – alone in my house – help her clean the bathroom. When I was fifteen years old my aunt said to me in my mother's presence: "Wouldn't it be nice if you got a job, saved up your money, and took your mother on a vacation to Miami Beach?"). One might also say that in berating me because I did not accompany my mother to the supermarket when I was thirteen, my aunt was currying favor with my mother, my aunt's younger sister.

The experience of narcissistic abuse in the dysfunctional family will have an important impact on the child's ability to form relationships or attachments. Children of dysfunctional families, either at the time, or as they grow older, may:

- Lack the ability to be playful, or childlike, and may "grow up too fast". They will have difficulty relating to peers in an age-appropriate way;
- Be an easy target of bullying or harassment through revictimization;
- Be a target of a type of group projection. Individuals who have been designated as black sheep in families may be predisposed to become scapegoats in groups;
- Have difficulty forming healthy relationships within their peer group;

- Spend an inordinate amount of time alone in solitary pursuits which lack in-person social interaction;
- Live a reclusive lifestyle without any spouse, partner, children, or friends;
- Strive (as young adults) to live far away from particular family members or the family as a whole; and
- Perpetuate dysfunctional behaviors in other relationships

Thoughts about Therapy Technique

At one point in the session the therapist said that I am not helping her help me. That assertion is of doubtful value.

It is clear to me that the therapist is fundamentally incapable, for psychological reasons, of working with a patient struggling with introjective as opposed to anaclitic pathology. She appears to have a psychological need to act out the role of a nurturing mother figure, a technique that will only be effective with anaclitic patients, who are plagued by feelings of helplessness and weakness; who have fears of being abandoned, and have strong wishes to be cared for, protected, and loved. It is well to keep in mind that *some patients require a therapeutic approach in which the therapist's "basic orientation towards the patient is a neutrally investigative one, free from a compulsive need to help and to love the patient, but open, rather to the sensing of hateful as well as loving feeling-tones in the therapeutic relationship."* Searles, H.F. "Phases of Patient-Therapist Interaction in the Psychotherapy of Chronic Schizophrenia."

The therapist is not informed about the specific therapy needs of introjective patients with a dismissive-avoidant attachment style. She does not have the tools in her toolbox to work with such patients. This was made clear at the very first session when the therapist asked me: "What feelings do you have when you are around people?" I replied: "I have

feelings of alienation.” The therapist then said, “Most of the people I work with talk about loneliness and fear of rejection.” The fact is that individuals with a dismissive-avoidant attachment style do not experience loneliness; they tend to agree with these statements: “I am comfortable without close emotional relationships”, “It is important to me to feel independent and self-sufficient”, and “I prefer not to depend on others or have others depend on me.” People with this attachment style desire a high level of independence. The desire for independence often appears as an attempt to avoid attachment altogether. They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others. They often deny needing close relationships. Some may even view close relationships as relatively unimportant. It’s not clear that the therapist knows the difference between dismissive-avoidant attachment and anxious (or fearful) avoidant attachment.

I grew up in the type of family that is conducive to the development of introjective (versus anaclitic) personality pathology. The family environment that encourages the development of introjective pathology is one in which important others have been controlling, overly critical, punitive, judgmental, and intrusive.

Individuals with an introjective, self-critical personality style may be more vulnerable to depressive states in response to disruptions in self-definition and personal achievement as opposed to anaclitic concerns centering on themes of closeness, intimacy, giving and receiving care, love, and sexuality. In anaclitic depression the development of a sense of self is neglected as these individuals are inordinately preoccupied with establishing and maintaining satisfying interpersonal relationships.

Introjective depressive states center on feelings of failure and guilt centered on self-worth. Introjective depression is considered more developmentally advanced than anaclitic depression. Anaclitic depression originates from unmet needs from an omnipotent caretaker (mother); while introjective depression centers on formation of the superego and

involves the more developmentally advanced phenomena of guilt and loss of self-esteem during the Oedipal stage. Patients with introjective disorders are plagued by feelings of guilt, self-criticism, inferiority, and worthlessness.

They tend to be more perfectionistic, duty-bound, and competitive individuals, who often feel like they have to compensate for failing to live up to the perceived expectations of others or inner standards of excellence. What is common among introjective pathologies is the preoccupation with more aggressive themes of identity, self-definition, self-worth, and self-control. In the pathologically introjective, development of satisfying interpersonal relationships is neglected as these individuals are inordinately preoccupied with establishing an acceptable identity. The focus is not on sharing affection—of loving and being loved—but rather on defining the self as an entity separate from and different from another, with a sense of autonomy and control of one's mind and body, and with feelings of self-worth and integrity. The basic wish is to be acknowledged, respected, and admired.

Introjective patients have distinct non-relational concerns that involve a “range from a basic sense of separation and differentiation from others, through concerns about autonomy and control of one's mind and body, to more internalized issues of self-worth, identity, and integrity.” The development of interpersonal relations is interfered with by exaggerated struggles to establish and maintain a viable sense of self. (My therapist focuses on my lack of relationships, emphasizing issues in my early attachment with mother, but consistently fails to consider how my *introjective traits* – traits that, in many ways, developed *after* early mother-infant attachment – may actually *interfere* with my ability to establish and maintain adult relationships.) Introjective patients are more ideational, and issues of anger and aggression directed toward the self or others, are usually central to their difficulties. An introjective patient will have more fully developed cognitive processes than patients who are concerned with

social relatedness. In therapy, introjective patients *need* to think primarily in sequential and linguistic terms as well as analyze, critically dissect, and compare details. Blatt, S.J and Shahar, “Psychoanalysis–With Whom, For What, and How? Comparisons with Psychotherapy.”

Significantly, “[p]atients with a dismissive-avoidant attachment style (introjective patients) respond best to psychodynamically-oriented interpretive therapy. Emotionally detached, isolated, avoidant, and wary introjective patients, *who tend to recall more family conflicts* and who view relationships with others, including the therapist, ‘as potentially hostile or rejecting’, found the exploratory emphasis in [interpretive therapy] liberating and conducive to therapeutic change.” Blatt, S.J and Shahar, “Psychoanalysis–With Whom, For What, and How? Comparisons with Psychotherapy.” The therapist’s observation that I am not allowing her to help me is problematic. Research supports the view that while anaclitic patients respond well to a caring, supportive therapy technique, introjective patients with a dismissive-avoidant attachment style respond best to interpretive psychodynamic work that emphasizes free association. Interpretive work was found experimentally to contribute significantly to the development of adaptive interpersonal capacities and to the reduction of maladaptive interpersonal tendencies, especially with more ruminative, self-reflective, introjective patients, possibly by *extending their associative capacities*. Supportive therapy, by contrast, was effective only in reducing maladaptive interpersonal tendencies and only with dependent, unreflective, more affectively labile anaclitic patients, possibly by containing or limiting their associative capacities. Blatt, S.J and Shahar, “Psychoanalysis–With Whom, For What, and How? Comparisons with Psychotherapy.” The therapist consistently limits my associations in therapy – a limiting technique that has been found to be effective only in anaclitic patients and can actually impair positive treatment outcomes in introjective patients. Blatt, S.J and Shahar, “Psychoanalysis–With Whom, For What, and How? Comparisons with Psychotherapy.”

The therapist fails to modify her technique to suit the needs of my introjective personality. It is recognized that it is important that therapists early adjust their orientation – based on the therapist’s assessment of whether the patient is primarily struggling with relatedness problems or self-related problems of guilt (self-criticism) and identity-definition – in order to enhance treatment outcomes. Werbart, A. “Matching Patient and Therapist Anacritic-Introjective Personality Configurations Matters for Psychotherapy Outcomes.” “Introjective depression, based on the sense that ‘I am a failure,’ responds to interpretive work, with the therapist as a listener, helping to elicit growth in an independent sense of self. Anacritic depression, based on the feeling that ‘I am not worthy of love,’ is effectively treated by a more assertive therapist, guiding the formation of relationships.” The therapist insists that she needs to be assertive and directive with me; the therapist’s viewpoint is not evidence-based.

Further, the therapist’s exclusive focus on attachment-related principles is not evidence-based. The therapist emphasizes her need to provide an attachment-based “emotionally corrective experience” without regard for introjective aspects of my personality problems. See Dubois-Comtois, K. “Attachment Theory in Clinical Work with Adolescents.” “Clinicians should . . . refrain from basing their entire intervention program solely on attachment-related principles.” “Specific attachment-based intervention should only be conducted when the clinician suspects that it is related to the [patient’s] main issue with regards to [social] maladaptation. In most cases, attachment-based intervention should be used in conjunction with other intervention strategies.

Therapy Session: January 29, 2019

The ability to represent certain longing feelings can be viewed metaphorically as each individual's ability to create a personal internal Linus-type security blanket
—Stanley I. Greenspan, *Developmentally Based Psychotherapy*.

It was sorely troubled Masters, spirits oppressed by the cares of life: in the desert of their troubles they formed for themselves an image, so that to them might remain of youthful love a memory, clear and firm, in which spring can be recognized.
—Richard Wagner, *Die Meistersinger von Nürnberg*.

As long as he could remember, he had been able to remove himself from his immediate environment, shutting off the bleak outside world by focusing on a self-created inner one.

—Jon Stock, *Dirty Little Secret*.

Today I see the diary pages excerpted here as my attempt at preserving an inner life in chaotic surroundings . . . Even the horrible aspects of [my early years] remain part of my emotional baggage. I am not willing to relinquish any of it; it gives me the strength on which I live to this day.

—Reverberations: *The Memoirs of Dietrich Fischer-Dieskau*.

In my letter about my therapy session on January 22, 2019 I offered the following thoughts about the deep nostalgic feelings I experience in connection with a day from childhood, December 24, 1966, the day after my thirteenth birthday. For my birthday that year my mother had purchased for me a recording of Beethoven's Violin Concerto. As a Christmas gift, my mother had purchased for me a recording of Wagner's opera, *Götterdämmerung*; it was a six-record set. The opera is about four hours long. Throughout my life I have felt a great connection with that opera and I listen to it often.

This is what I wrote in my previous letter: “*In my case adult feelings of nostalgia seem related to my tendency to retreat into solipsistic fantasy – an abstracted world of music and literature that doesn’t involve feelings centering on past satisfying connections with others. My feelings of nostalgia are a deeply idealized state, an otherworldly condition, removed from pain and sorrow. My feelings of nostalgia for the time of my thirteenth birthday that I described in my therapy report center concretely on my immersion in the classical music records my mother purchased for me at that time and the deeply emblematic idea of the epic journey (the trek through the blizzard with my mother), which Shengold associates symbolically with traversing one’s mental interior as in psychoanalysis: “the narcissistic elation that comes from self-understanding.” See, e.g., Shengold, L. “The Metaphor of the Journey in ‘The Interpretation of Dreams’.” It is an omnipotent or manic state of triumph over human connectedness rather than the imagining of past social pleasures. A knowledgeable trauma therapist will be familiar with the plight of the creative and sensitive child who finds himself in a disturbed family environment – his ‘attempt at preserving an inner life in chaotic surroundings.’”*

At the current session I spoke again about December 24, 1966 – my most nostalgic day. I talked about my intense nostalgic feelings for the opera *Götterdämmerung* and my first exposure to the music at age thirteen. I related my nostalgia to transitional functioning. I said, “Last time you said maybe my nostalgic feelings are related to warm feelings I had about my interactions with my mother that day. But I don’t think that’s the case at all. My nostalgic feelings are for the internal world I created for myself that day. My nostalgic feelings are for my internal world and my investment in that world.” The therapist replied, “When was the last time you listened to that music.” I said, “This morning.” (I am always listening to *Götterdämmerung!*) My therapist asked: “Did the music remind you of your mother?”

My therapist could not engage with my idea that my nostalgia was abstract and nonpersonal. She seemed unable to process the idea that my

nostalgia related to my investment in my inner world. I thought, “doesn’t this point to the concrete nature of her thinking?” She didn’t even inquire into what I meant by saying I had an investment in my inner world. Why did she immediately return to the idea that the music concretely related to memories of my mother?

Is this the reason my therapist is caught up with attachment theory – because of its concrete nature? Attachment theory focuses on the mother and other significant people in the child’s environment as real, concrete objects. The theory concerns the patient’s attachment to the concrete object of his mother and others. Psychoanalysis, on the other hand, is concerned with the individual’s inner world and symbolization. Classical analysis is concerned with the way the individual internally represents his mother, not simply with the real object of the mother.

I thought of the small child and the transitional object, say a teddy bear. In Winnicott’s formulation the teddy bear is a symbol of the mother (or mother’s breast: Winnicott, after all, was a Kleinian); it *stands for* the mother. The teddy bear *symbolizes* the union of the child’s inner world with external reality. It is the *transitional space* between subjective experience and external reality. The transitional object is not simply a memory item. It has specific a psychological function relating to individuation, the child’s loss of omnipotence, and symbol formation.

And this is crucial. Even for the small child, the teddy bear does not remind the child of his mother. It is a symbol of the mother, even for the small child. If you say to the small child, “Does your teddy bear remind you of your mother?” – he’ll think you’re loony. He will likely say, “No, silly. My mother is my mother. And my teddy bear is my teddy bear.” If he is separated from the teddy bear, he will having longing for the *teddy bear*. He will not see his mother as a substitute for the lost teddy bear. I know that from personal experience. My younger niece in childhood became frantic when she misplaced her blanket – despite the fact that her

mother was right there. Why is it that her mother could not soothe her if the blanket was simply a *memory item* for her mother? It is only at an unconscious level that the child appreciates the connection of the transitional object with mother.

There was something concrete about the therapist asking, “Does listening to the music remind you of your mother?” What was she doing in that question? Was she projecting her concrete attachment (her lack of internal representation) of her mother onto me? I thought immediately, “Is this why she is so rigidly attached to her misreading of attachment theory?” She is concretely attached to her mother and her internal representation of her mother is impaired. Maybe.

In an earlier letter (October 2, 2018) I had made the following observations about the transitional nature of psychodynamic psychotherapy and how a therapist whose thinking was concrete would have difficulty dealing with the transitional, symbolic aspects of psychodynamic therapy:

I am attracted to the idea that psychodynamic therapy constructs in the clinical situation a framed, transitional area in which the patient's inner world can find expression. The patient creates and recreates unconscious processes, and presents these in a manner which resonate with the therapist's shared sense of symbols. By articulating these shared symbols, the patient invites the therapist into this intermediate area of experiencing. The patient chooses symbols and images of a common language, and finds comfort not available in himself. He invites the therapist into this in-between space, beyond the merely private, subjective, or psychological, which serves as a resting place between inner and outer reality, between psyche and language. In this way, psychodynamic therapy is like the child's experience in imaginative play. Such a view of psychotherapy requires that the therapist have a capacity for symbolization (that is, a capacity to see the metaphoric meaning behind the literal) and a willingness to acquiesce in the patient's idiosyncratic symbol making: speaking metaphorically, a capacity to

recognize that the patient's "play-dough" – literally, a concoction of flour and water – is not simply a concoction of flour and water, but has symbolic meaning as, for example, a snowman or an octopus. Cf. Praglin, L. "The Nature of the 'In-Between' in D.W. Winnicott's Concept of Transitional Space and in Martin Buber's *das Zwischenmenschliche*."

I had read Winnicott's original paper on transitional objects and transitional functioning, which clued me into something startling at the session. Winnicott wrote: "This intermediate area of experience, unchallenged in respect of its belonging to inner or external reality, constitutes the greater part of the infant's experience, and throughout life is retained in the *intense experiencing* that belongs to the arts and to religion and to imaginative living, and to creative scientific work."

Now I ask you: If a creative virologist has nostalgic feelings for a groundbreaking scientific discovery he had made years earlier on the day he last saw his mother before she died – is his nostalgia related to his memory of his mother? Credibly, he might have nostalgic feelings only for his scientific discovery. We can't say for sure. His nostalgia *might be* for his mother. Then again, his nostalgia for that day could be purely narcissistic. We don't know.

Why is my therapist so sure that the opera *Götterdämmerung* is concretely related to memories of my mother?

The scientist's work, according to Winnicott, could be transitional – a merger of the inner subjective world of wishes and fantasies with the external world of real objects. For me, *Götterdämmerung* may be transitional in the sense that the story and the music (the objective object) resonates with my inner wishes and fantasies. It's possible my nostalgia is purely narcissistic. The day I *discovered Götterdämmerung*.

An important question is whether my nostalgic recollections of my thirteenth birthday promote emotionally-rewarding recollections of positive feelings about my mother, or whether, alternatively, my nostalgia, seen as a transitional phenomenon, is in some way sensed to be corrective, and the experience of nostalgia provides me with the kind of emotional validation which I long for, yet never experienced. In that sense my nostalgia would not be a revival of actual emotionally-satisfying experience with my mother, that is, a recollection of actual past empathic experiences, but a *compensation* for my mother's (or father's) empathic failures.

I would like to offer the tentative idea that my nostalgic feelings for my thirteenth birthday are related to my intense emotional experiencing in other areas of my psychological life, such as, my letter writing and my preoccupation with my former primary care doctor, Dr. P-. I see these preoccupations as transitional in nature — transitional objects, as it were — and I suggest that I may have a special need for transitional objects as a way of coping with intense psychological pain. I suggest that my transitional functioning is also related to my unusually high level of autonomy.

Both music and nostalgia have been seen as transitional phenomena. Music has been seen to dissolve the boundaries between present and past, which relates to both the emotive power of music and the promotion of nostalgia. Blum, L.D. "Music, Memory and Relatedness." Nostalgia is a "transitional phenomenon," blurring distinctions especially between time and space. Clark, R.B. "A Well-Traveled Mudhole": Nostalgia, Labor, and Laughter in *The Reivers*. Music is connected with both the concrete world of bodily sensations and the symbolic expressions of culture, and may be an important transitional phenomenon on both unconscious and conscious levels. Lombardi, R. "Time, Music, and Reverie."

The letters I write about my therapy experience fall in an intermediate area between my inner reality and external life, namely, my real relationship with my therapist. The letters feature verbatim reports of therapy dialogue (external life) as well as my subjective reflections on the therapy sessions.

My idealized preoccupation with my former primary care doctor, Dr. P–, can be seen as transitional in nature if one views Dr. P– as serving a “selfobject” function for me. In self psychology, selfobjects are external objects that function as part of the “self machinery” – “i.e., objects which are not experienced as separate and independent from the self.” They are persons, objects or activities that “complete” the self, and which are necessary for normal functioning particularly in persons with narcissistic pathology. Selfobjects serve the individual's mirroring, alter ego, and idealizing needs. Through the use of selfobjects the individual attempts to make good deficits left by perceived failures of the mother.

These attempts include the setting up of relationships with persons whose empathic capacity is in some way sensed to be corrective, and the setting up of relationships with selfobjects are in part created by the individual to provide himself with the kind of validating empathic experience which has been longed for, yet never experienced.

Selfobjects are related to transitional objects in that both selfobjects and transitional objects involve the sharing of mental functions or the merger of self (the inner world) and other (the external world). Palombo, J., “Mindsharing: Transitional Objects and Selfobjects as Complementary Functions.”

The fact that the *story* of Götterdämmerung resonates with my inner world has intriguing psychological implications. The opera Götterdämmerung, as well as the complete Ring Cycle of which it is a part, has been interpreted as the tale of a dysfunctional family. Jean Shinoda Bolen, M.D., a Jungian analyst, has used archetypal psychology, dysfunctional relationship

psychology with its insights into narcissism and co-dependency, and patriarchy to elucidate Wagner's Ring Cycle. "The Ring of Power: A Jungian Understanding of Wagner's Ring Cycle." Bolen sees the character Siegfried as a prototype of an emotionally numbed, successful son of a dysfunctional family. Siegfried has not been genuinely loved and therefore cannot recognize or value unconditional love when he receives it. *Ring of Power: Symbols and Themes Love Vs. Power in Wagner's Ring Cycle and in Us- A Jungian-Feminist Perspective.*

The character Alberich has been seen as a psychological prototype of dismissive-avoidant disorder. Alberich decides that the renunciation of love is preferable to the pain and danger of relationship; instead, he seeks control and mastery over the environment. Connors, M.E., "The Renunciation of Love: Dismissive Attachment and its Treatment."

In *Götterdämmerung* the characters Siegfried and Gunther swear an oath of Blood Brotherhood. Siegfried is later accused of violating that oath and is murdered in vengeance; his killer cries out, "I have avenged perjury" [Meineid in the German text]. Blood Brotherhood fantasy has been viewed psychoanalytically as being rooted in a lack of maternal empathy and resulting narcissistic pathology. Cowen, J. "Blutsbrüderschaft and Self Psychology in D.H. Lawrence's *Women in Love*." The fantasy has been seen in individuals who, on an experiential level, seek affirmation in relation to the idealized paternal imago. The fathers of such individuals meet few if any of the son's needs for nurturance. (Wagner's biological father died when he was six months old; he experienced father hunger throughout his life). These individuals' need for male nurturance in adult life, emerging in times of crisis or transition, is revived in the service of stabilizing a fragile self. A pattern of idealization, attempted merger and disappointment in regards to significant male figures is compulsively repeated in an attempt to cure the original traumatic disappointment in relationship with the father, but the deficit is never healed. Such individuals will have an intense need for male selfobjects. Blood

Brotherhood symbolizes male bonding. The theme of perjury in *Götterdämmerung* can be understood as symbolic of traumatic disappointment with or betrayal by an idealized male figure. It is useful to see my obsessive preoccupation with Dr. P–, a putative selfobject, as rooted in Blood Brotherhood fantasy. It is ironic and possibly psychologically significant that I filed a federal civil rights criminal complaint against Dr. P– in March 2018, alleging that Dr. P–'s prior affidavit filed in support of a civil protection order against me had been *perjured*.

Trauma and Mindsharing Function

At the January 22 session I described an early childhood physical injury in my mouth that occurred at age two-and-a-half. A curtain rod I had placed in my mouth punctured the soft palate when I fell. Might the injury have been psychologically traumatic?

Fernando describes the psychological consequences in some children of early maltreatment or traumatic injury. Such stressors lead to a distortion in ego-superego interaction and interfere with normal superego maturation. The tendency to massive superego externalization, normal in early latency, is never outgrown and results in many of the characteristic features of the "exceptions," or the entitled victim. Fernando, J. "The Exceptions: Structural and Dynamic Aspects" My personality shows signs of the entitled victim, a character structure that features a grandiose sense of entitlement.

Fernando details the case of a patient who had severely repressed demands for recompense for a physical injury she suffered in childhood and who for this reason was attracted to (more accurately, obsessed by) persons who displayed the character type of the "exceptions."

The patient, a young adult, had suffered a broken leg in early childhood. According to Fernando, the injury and its aftermath (parental blaming

behavior) caused a disturbance in superego development in which the early idealized parental images were never metabolized as in the normal person, and the individual's superego remained warped. Such individuals attempt to recapture in their interpersonal relations in adulthood representations of their early idealized parental images. Fernando's patient was obsessed with two persons, her only friends.

The relative lack of superego maturation and integration in the exceptions (or entitled victim) affects the maturation of the ego ideal. It interferes with the deconcretization of the ego ideal and its integration into the personality as a substructure within the superego system, a process that normally takes place definitively in late adolescence. This interference was evident in Fernando's patient who found it impossible to relinquish her attachment to the idealized images of her parents and instead began a prolonged attempt, beginning in late adolescence, to recapture her ideals in concrete form in her relationship with her two friends.

In some sense Fernando's patient sought a *mindsharing* function in relation to her two friends. The friendships, in a manner of speaking, served a transitional function for the patient. The personalities of the patient's friends resonated with her internalized idealized images of her parents. Like the child's teddy bear, the friends symbolized for the patient a union of inner wishes and fantasies (her internal idealized image of her parents) with real external objects.

Artistic Interests, Transitional Functioning, and Autonomy

Winnicott observes that throughout life transitional objects are retained in the *intense experiencing* that belongs to the *arts* and to imaginative living. The intense experiencing I derive from the arts and creative imagination is transitional in nature. Winnicott located creative thinking in an intermediate area between inner reality and external life. "It is an area that is not challenged, because no claim is made on its behalf except that

it shall exist as a resting-place for the individual engaged in the perpetual human task of keeping inner and outer reality separate yet interrelated.” Hollway, W. “In Between External and Internal Worlds: Imagination in Transitional Space,” quoting Winnicott.

The use of creative imagination to generate for one's self a rich inner world that is expressive of individual preferences promotes self-reliance and autonomy, which has been linked to the individual's ability to withstand a chaotic environment or extreme circumstances.

In the child, the capacity of the transitional object to comfort and soothe represents a way station on the road to an increasing *autonomy* from the need for actual physical proximity to the caregiver and an increasing internalization of safe haven and secure base functions. Eagle, M.N., *Attachment and Psychoanalysis: Theory, Research, and Clinical Implications*.

Nonpersonal interests, such as artistic interests and creative imagination, play a central role in maintaining personality intactness and integrity, particularly in extreme circumstances. Interests and values serve a "something to live for" function in extreme circumstances, and presumably in chaotic families. There are many first-person accounts of prisoners in concentration camps that describe the role that these interests and values played in upholding psychological integrity. Whether or not as an adult one has acquired long-lasting interests is not a casual affair or peripheral aspect of an individual's behavior, but a central feature of personality. Safan-Gerard, D. *Chaos and Control: A Psychoanalytic Perspective on Unfolding Creative Minds*, referencing the work of Morris Eagle.

From his own observations when he was a prisoner in Dachau and Buchenwald, Bruno Bettelheim concluded that the prisoners who gave up and died were those who had abandoned any attempt at personal

autonomy; who acquiesced in their captors' aim of dehumanizing and exercising total control over them. Storr, A. *Solitude: A Return to the Self.*

Strong interests reflecting a well-developed internal world preserved the *autonomy* and lives of some concentration camp inmates. An example of the deliberate exercise of recall in a well-furnished mind in order to prevent breakdown is seen in one musical camp inmate who found herself herded into a small room with dozens of others, where they were kept for many days with no food and no facilities of any kind. Most of the others went out of their minds, but she kept sane by methodically going through the four parts of each of the Beethoven string quartets, which she knew individually by heart. Storr, A. *Solitude: A Return to the Self.*

From an attachment perspective it is noteworthy that it was the inmate's preservation of personal autonomy (her investment in her inner world), rather than relationships or attachments with other inmates, that preserved her sanity. May I suggest that a child's adaptation to early maternal empathic failures (through the development of avoidant traits) can be protective for the adult in stressful or extreme situations? See, Ein-Dor T., Reizer, A., Shaver P.R., and Dotan E., "Standoffish Perhaps, but Successful as Well: Evidence that Avoidant Attachment Can Be Beneficial in Professional Tennis and Computer Science."

Again, I ask: Are my nostalgic recollections of my thirteenth birthday related to positive associations to my mother only, or are they rooted in transitional experience, autonomy, the attempt to compensate for maternal empathic failures, and the use of an inner life as a defense against a chaotic family environment?

Therapy Session: February 5, 2019

I was so identified with my secret double that I did not even mention the fact in those scanty, fearful whispers we exchanged.

—Joseph Conrad, *The Secret Sharer*.

[For] several days after a snow the road is [not] much traveled. Judge how surprised I was the other evening as I came down [the road] to see a man, who . . . looked for all the world like myself, coming down the [cross-road] . . . I felt as if I was going to meet my own image in a slanting mirror . . . as we slowly converged . . . at the same point as if we were two images about to float together . . . I verily expected to take up or absorb this other self and feel the stronger by the addition . . . But I didn't go forward to the touch. I stood still in wonderment and let him pass by.

—Robert Frost, *Letter discussing the writing of "The Road Not Taken."*

[Two analysts identified] the figure [Frost] described as a "double," [and one emphasized] the strength Frost felt he achieved from the virtual but not actual contact or merger. Clinically, in the course of analyses, we find that such fantasies of fusion or merger depict a wished-for or defensive union with a powerful maternal or paternal figure of childhood.

—Jules Glenn, *"Robert Frost's 'The Road Not Taken'—Childhood, Psychoanalytic Symbolism, and Creativity."*

When Wagner's stepfather was upon his deathbed, he heard the boy trying to pick out some melodies on the piano and said, "What if the lad should possess musical talent?"

—Louis C. Elson, *Modern Music and Musicians*.

It was no longer a relationship of dependence, but one of equality and reciprocity. He could be the guest of this superior mind without humiliation, since the other

man had given recognition to the creative power in him.

—Hermann Hesse, *Narcissus and Goldmund*.

The following thoughts highlight a problem that will confront the therapist who relies on supportive, relationship-based therapy (recommended for anaclitic depressives) in treating an introjective depressive for whom insight-oriented, interpretive work is considered the treatment of choice. There will be an ever-present risk of miscommunication where a relationship-based therapist, who focuses on interpersonal issues, or views psychological issues from an interpersonal perspective, offers relationship-based interventions to an introjective patient (largely unconcerned with social issues), who focuses on self-oriented concerns.

It is well to note that the Psychodynamic Diagnostic Manual advises therapists: “The introjective type [of patient] tends to respond better to interpretations and insight, while the anaclitic type [of patient] tends to respond better to the actual therapeutic relationship.”

According to object relations theory, depression is caused by problems people have in developing representations of healthy relationships. Depression is a consequence of an ongoing struggle that depressed people endure in order to try to maintain emotional contact with desired objects. There are two basic ways that this process can play out: the anaclitic pattern and the introjective pattern.

Anaclitic depression involves a person who feels dependent upon relationships with others and who essentially grieves over the threatened or actual loss of those relationships. Anaclitic depression is caused by the disruption of a caregiving relationship with a primary object and is characterized by feelings of helplessness and weakness. A person with anaclitic depression experiences intense fears of abandonment and desperately struggles to maintain direct physical contact with the need-gratifying object.

Introjective depression occurs when a person feels that they have failed to meet their own standards or the standards of important others and that therefore they are failures. Introjective depression arises from a harsh, unrelenting, highly critical superego that creates feelings of worthlessness, guilt and a sense of failure. A person with introjective depression experiences intense fears of losing approval, recognition, and love from a desired object.

Individuals with an introjective, self-critical personality style may be more vulnerable to depressive states in response to disruptions in self-definition and personal achievement as opposed to anaclitic concerns centering on libidinal themes of closeness, intimacy, giving and receiving care, love, and sexuality. In anaclitic depression the development of a sense of self is neglected as these individuals are inordinately preoccupied with establishing and maintaining satisfying interpersonal relationships. Introjective depressive states center on feelings of failure and guilt centered on self-worth.

Introjective depression is considered more developmentally advanced than anaclitic depression. Anaclitic depression is primarily oral in nature, originating from unmet needs from an omnipotent caretaker (mother); while introjective depression centers on formation of the superego and involves the more developmentally advanced phenomena of guilt and loss of self-esteem during the oedipal stage. Patients with introjective disorders are plagued by feelings of guilt, self-criticism, inferiority, and worthlessness. They tend to be more perfectionistic, duty-bound, and competitive individuals, who often feel like they have to compensate for failing to live up to the perceived expectations of others or inner standards of excellence.

What is common among introjective pathologies is the preoccupation with more aggressive themes (as opposed to libidinal) of identity, self-definition, self-worth, and self-control. In the pathologically introjective, development of satisfying interpersonal relationships is neglected as these individuals are inordinately preoccupied with establishing an acceptable identity. The focus is not on sharing

affection—of loving and being loved—but rather on defining the self as an entity separate from and different than another, with a sense of autonomy and control of one’s mind and body, and with feelings of self-worth and integrity. The basic wish is to be acknowledged, respected, and admired.

In the following report my therapist had posed a question, apparently from a relationship-based, anacritic perspective, while I responded to the question from a self-oriented, introjective perspective. The therapist seemed unable to process my response to the question she posed.

PATIENT: Last week we talked about my thirteenth birthday and how there was a blizzard that day. My mother and I trekked through the blizzard to pick up my birthday cake. I talked about how I had nostalgic feelings for that day. You said that maybe I had nostalgic feelings about that day because I associated that day with my mother. I don’t think so. I think I had nostalgic feelings about that day because I had nostalgia for my inner world that day—the classical music recordings that my mother had bought as a gift for my birthday. I get lost in that inner world. So last week, at our last session, I don’t know if you remember, it was snowing lightly and you pointed out the window and asked me what the snow reminded me of as I walked over here today. And I said it didn’t remind of anything in particular.

[I sensed that the therapist was inquiring into whether walking through the snow on my way to the clinic the previous week reminded me of my mother or reminded me of my trek with my mother through the blizzard on my thirteenth birthday. In fact, the snow on January 29 did not remind me of my mother or my thirteenth birthday.]

PATIENT: So I want to talk about something related to what you asked. My thoughts about the snow. And a funny thing happened last Friday, a

few days after our last session. It had snowed that morning. I don't know if you remember. I woke up in the morning and there was a layer of snow on the ground. It was maybe two inches. So, I didn't feel like going to the library that day. I just stayed home and relaxed. At about noon, I put on a recording on my stereo, the Schubert impromptus. It's piano music. And it lasts about an hour and ten minutes. So I was laying on my couch and listening to the music and I fell into a reverie for the whole time I was listening to the music. I imagined that I was Beethoven on his deathbed. It was March 1827, in Vienna. And I was laying there and Franz Schubert came to visit Beethoven. And he went to an adjoining room and he was playing on the piano. He played his impromptus for Beethoven. The funny thing is that that could never happen because Beethoven was deaf. If somebody played the piano in another room, Beethoven wouldn't be able to hear it. But, you know, I blocked that out for some reason. It only occurred to me later that my fantasy didn't make any sense. It could never happen. So I imagined Beethoven listening to Schubert and thinking, "Wow. This music is terrific."

So I thought that was interesting. Because you asked me last week what I thought about when I saw the snow. So that fantasy about Beethoven was inspired by the snow. So that's my answer to the question you asked: "How do you feel when you see snow? What does the snow remind you of?" So last Friday, that's what the snow reminded me of. That's what the snow made me think of. And I guess what's interesting is that my fantasy shows a dual identification about me and Beethoven. I was both the dying Beethoven listening to the young Schubert, and the young Schubert playing the piano for the dying Beethoven.

And you know, I want to say something about nostalgia. This fantasy I had about Beethoven last Friday and listening to the Schubert impromptus, I'll probably remember that for years, maybe till the day I

die. And I suspect even years from now, I'll have feelings for that day I listened to Schubert on a snowy day in February. What I'm saying is that I have feelings of nostalgia for the inner world I create, not necessarily feelings of nostalgia about the past because it reminds me of positive feelings I had about people. You're just too people-oriented. You can't get inside the head of somebody who isn't people-oriented.

[The therapist sat silently. She said nothing. She offered no feedback. It was as if my report was meaningless for her. My report was not other-oriented, but self-oriented and, perhaps for that reason, my report did not interest the therapist. Keep in mind, the therapist herself had opened the door to my report of this fantasy. My report was a direct response to the therapist's question at the previous session, "When you see the snow, what does it remind you of?" It's as if the therapist tends to filter out aspects of my therapy reports that do not concern my relationships with other people, ignoring the fact that even a patient's seemingly abstracted, self-oriented fantasies will tend to be derivatives of the patient's relationships in childhood.]

I thought of how a psychodynamic therapist who does insight-oriented, interpretive work might respond to my reported fantasy.

FICTITIONAL PSYCHOTHERAPIST: Your fantasy represents a dual identification. Yes. That's an important insight. You were the dying Beethoven, but you were simultaneously the young Schubert. It reminds me of what you were talking about several weeks ago. You told me about the Twitter posts you wrote about your former primary care doctor, Dr. P— that featured imaginary dialogue between you and him. In writing the fictional dialogue, imaginary conversations between you and Dr. P—, you were both Dr. P— and yourself. For you, Dr. P— was a dissociated image of yourself. You said the Twitter posts were humorous, but they also

featured another quality. You said that in the fictional dialogue you created, Dr. P— took on the role of an authority figure. You said you had him chastise you in the posts; in the dialogue you created, he would ridicule your foibles, your ridiculousness, your childishness, your obsessions. You said that he was like an older brother or father figure for you in your imagination. I think you said that he was a “superego figure,” if I recall correctly. You know, that reminds me of the fantasy you told me a few minutes ago. You were the wise old Beethoven and Schubert was the lesser figure. And the old master had allowed the young musician to play his compositions for him. I suppose somewhere you have the idea that Schubert idealized Beethoven and wanted the old master’s approval. Schubert hungered for that approval in your fantasy. He wanted to impress the old man. And Beethoven had permitted the young Schubert to entertain him in a vulnerable and meaningful moment, his dying moments. So we see superego issues in your fantasy about Beethoven, perhaps. You are recreating your relationship with your father. You desperately wanted your father’s approval. Every father is both a son and a father. He is father to his son and he is the son of his own father. So every father-son relationship involves a dual identification. In that sense, there is an archetypal quality to your fantasy.

I want to get to something else. The issue of envy. You mentioned how you feel comfortable with people who are smarter than you. You worry that people who aren’t as smart as you will envy you and aggress on you. You seek safety in gifted people. A safety from envious attack. And I see that in your fantasy. Schubert symbolized that safety for you. Schubert was perhaps a lesser composer than Beethoven, perhaps less gifted. But perhaps you thought that was satisfying to you because in your fantasy Schubert could be free of envious attack from Beethoven. Schubert could be free to express himself fully, express his gifts, and not fear envious retaliation. Certainly, Beethoven would not be envious of a young

composer. So your fantasy also related to this issue of envy. Your fear of envy. But also the idea that Schubert both idealized and envied Beethoven. Isn't that the way you talked about Dr. P—? That you both envied and idealized him? Didn't you say that that was an aspect of your transference with Dr. Palombo—that you both idealized and envied him? In your therapy sessions with Dr. Palombo you were the young Schubert playing the piano for the master, Beethoven—hungering for his approval. I am going to make a wild interpretation, but on February 1 when you had this fantasy, were you thinking about Dr. Palombo? Were you having troubling thoughts about his mortality for some reason, perhaps? I don't know.

[In fact, Dr. Palombo's 85th birthday was on February 4, 2019.]

You know I want to say something else. Your observations about the superego and Dr. P— are astute and sophisticated. Psychoanalysts talk about a twin fantasy. A fantasy about having an identical twin. A common daydream is the fantasy of possessing a twin. It is a conscious fantasy in childhood, as the result of disappointment by the parents—and retaliatory destructive impulses directed by the child in fantasy against his parents—in the Oedipus situation, in the child's search for a partner who will give him all the attention, love and companionship he desires and who will provide an escape from loneliness and solitude. The parents have been unable to gratify the child's instinctual wishes; in disappointment his love turns to hate; he now despises his family and, in revenge, turns against it. He has death-wishes against the former love-objects, his parents, and as a result feels alone and forsaken in the world. So he erects a fantasy twin who will comfort the child and ease his loneliness. A further element in many daydreams of having a twin is that of the imaginary twin being a complement to the daydreamer. The child endows his twin with all the qualities and talents that he misses in himself and desires for himself. The

twin thus represents his superego. For Schubert, Beethoven had all the qualities and talents that he desired for himself. For you, Dr. Palombo had all the qualities and talents that you desired for yourself.

In works of creative literature there is the theme of “the double” or Doppelgänger. These are stories that concern two protagonists who are identical to each other or who mirror each other. You may have read Joseph Conrad’s story, *The Secret Sharer*. That’s a story about a doubling of characters. Doppelgänger stories have traditionally been interpreted in Freudian terms as allegorizing the struggle for domination between the ego and the id, or alternatively the superego. Most of the nineteenth-century stories of identical alter egos contain, on the one hand, a level of psychological realism, where the doppelgänger is a hallucination brought on by madness, and, on the other hand, a theological level where the protagonist represents the great sinner and his phantom doppelgänger is either a tempting devil or an admonishing guardian spirit, a personified conscience, a scenario which, of course, easily translates into Freudian terms as the pull of unconscious desires versus superego guidance. In your fantasy relationship with Dr. P—, he was a hallucination, a critical, admonishing spirit that you summoned up from your inner world. In your relationship with Dr. Palombo, one could say that you saw him as your double, a kind of secret sharer, who offered you superego guidance. You are a creative person, Mr. Freedman and I am going to go out on a limb and suggest that perhaps you imagined that you shared that trait with Dr. Palombo—that you saw him as a creative person also. That, perhaps, contributed to your sense of twinship with him. They say that some creative people seek out a double with whom they can create and bring forth, through their collaboration, something new, a creation of some sort—the way Freud and Fliess did with the new ideas of psychoanalysis. Fliess was a close friend of Freud’s, a fellow medical doctor. For Freud, Fliess was a kind of Doppelgänger, a double, who

inspired Freud; he was somebody with whom Freud shared his developing ideas about the mind. In some sense psychoanalysis is a product of the secret sharer relationship between Freud and his friend.

So, yes, we might say that you see Dr. P— as your twin and your superego who chastises you and who is critical of you, who belittles you in jest. Perhaps the silly humor of your Twitter reflects just how frightening your father's chastisement was for you. In turning to humor on your Twitter as an adult to express this chastisement from Dr. P—, you were masking just how terrified you were of your father's chastisement when you were small. Terrified of his anger, his rages. Your humor—the silly humor of your Twitter—was a defensive reversal of your childhood feelings of terror in relation to your father—the primal superego figure.

I am thinking of the Oedipal aspects of the twin fantasy. The twin fantasy, according to theory, grows out of the child's destructive, retaliatory impulses against his parents, perhaps, especially the child's father. Going back to your fantasy about Beethoven and its possible connection to your transference relationship with Dr. Palombo—if indeed, the Beethoven figure of your fantasy represented Dr. Palombo—perhaps, your positive conscious feelings for the Beethoven figure masked your murderous hatred of Dr. Palombo. You would like to see Dr. Palombo destroyed, like the child who develops a twin fantasy as a sequel to his unconscious desire to destroy his parents. These destructive impulses are also driver of your conscious idealization and tender feelings toward Dr. Palombo.

Those are just some ideas that we can return to at a later time, if warranted.

Any thoughts?

[“Franz Kafka in *Letter to his Father* and Nathalie Sarraute in *Enfance* both employ the device of an imaginary dialogue to frame an accusation against a parent.” In my imaginary conversations with Dr. P— on Twitter, I employed the device of an imaginary dialogue to frame accusations against myself. “He” (Dr. P—) became the accuser. But it was actually “I” who was accusing myself. It was more acceptable to my ego for “him” to say these things about me. This highlights the dissociative element of the Twitter posts. The following thoughts about the rhetorical device of a dialogical exposition are instructive: “Are there rhetorical strategies for framing an accusation so that it seems meeker, milder, more acceptable to the accused . . . ? Based on autobiographical writing by Franz Kafka and Nathalie Sarraute, both of whom [like me] were lawyers by profession, I propose that one such way is to frame the accusation as *an imaginary dialogue*. In this scenario, the autobiographer pretends to relinquish the reins. He or she divests the autobiographical ‘I’ of its sole authority by building in a contrasting point of view.” Martens, L., “Framing an Accusation in Dialogue: Kafka’s *Letter to His Father* and Sarraute’s *Childhood* (emphasis added).”]

[Twinship transference goes to the core of my schizoid character pathology, that is to say, my merger hunger (or intense object need) and simultaneous fear of engulfment. What are the meanings and functions of a transference paradigm of a fantasied twin relationship with the analyst? Twin transference in the analysis of non-twins has been reported infrequently in the psychoanalytic literature, except by Kohut and his co-workers, who refer to twinship transference as a variant of narcissistic mirror transference. Such narrow definition tends to reduce the complexity of the wish for a twinlike relationship with the analyst. Analytic data show the advantages of examining twin transference within structural theory, in terms of the multiple functions served by this rather primitive transference paradigm, rather than reducing it only to one

variant of the need for certain mirroring functions. Twin transference, together with all twin fantasies, may be seen to subserve multiple functions, including gratification and defense against the dangers of intense object need. In this formulation, the twinlike representation of the object provides the illusion of influence or control over the object by the pretense of being able to impersonate or transform oneself into the object and the object into the self. Intense object need persists together with a partial narcissistic defense against full acknowledgment of the object by representing the sought-after object as combining aspects of self and other. An open question is the specific representation of the needed object in certain primitive transference paradigms instead of exclusive emphasis on the functions required of the object. Intense early needs of an object are best understood analytically within a conflict model in which they are modified by multiple wishes, drives, fears, dangers, and needs for defense. Coen, S. J. and Bradlow, P.A., "Twin Transference as a Compromise Formation.]

[At a later point in the session, the therapist spoke of my lack of progress in therapy and tried to persuade me to quit therapy. This was the first time in my nine months of treatment that the therapist spoke of my lack of progress. I had not complained about a lack of progress and never have. I would not complain about a lack of progress precisely because I, unlike the therapist, recognize that progress in therapy is an unconscious process. The therapist ignored the fact that the Code of Ethics for social workers imposes an affirmative duty on the social worker to terminate where she believes there has been no progress. The patient has no duty to do anything; there is no such thing as a "patient's duty to quit therapy." The therapist's attempt to manipulate me to quit to avoid her having to terminate me seemed to be unprofessional. The therapist stated that she would terminate my treatment and issue a letter of termination the following week. The therapist's action seemed unplanned and precipitous.

Certainly, nothing that went on in the first twenty-five minutes of the session indicated that she had previously planned to terminate. The session had been positive and relationship-oriented. I talked about my feelings about relationships. I talked about an old girlfriend. The therapist seemed pleased with the material I presented.]

The Dream of Beethoven

After I retired on the evening of Thursday December 12, 2013—some years ago—I had the following dream about the composer, Ludwig van Beethoven. During the period July 2013 to June 2015 I was in out-patient psychotherapy with a psychiatrist named Mohammed Schreiba, M.D. (St. Elizabeths Psychiatry Residency Training Program, Earle Baughman, M.D., supervisor). Dr. Shreiba was an older gentleman in his late 60s. He was perhaps ten years older than I. He was originally from Syria, but had lived and practiced psychiatry in Vienna, Austria for many years. He was a literate individual; he said that he had read Faulkner's novel, *The Sound and the Fury* in Arabic. He mentioned that he had worked at the Allgemeines Krankenhaus, the same hospital in Vienna where Freud had worked. He was a kindly individual with whom I got on well. I had peculiar transference feelings for him. I projected onto him the qualities of pain, suffering, vulnerability, loss, death and mourning. I suspect these projections were based to some degree on the fact that I knew Dr. Shreiba was Syrian, and I imagined that he was affected by the Syrian civil war. But that could not be; I'm sure Dr. Shreiba had left Syria many years earlier, before the war. The following dream seems to be symbolic of a psychotherapy session: two individuals of different status, alone in a room, talking to each other.

Years earlier, in 1990, I had a psychotherapy session with Stanley R.

Palombo, M.D. in which I had brought along a book: a biography of the playwright Clifford Odets written by the psychoanalyst Margaret Brenman-Gibson. Odets wrote the play *Paradise Lost*, a particular favorite of mine. Dr. Palombo was twenty years older than I. I read to Dr. Palombo from the preface of the book that described Odets' premature death in a hospital room in Hollywood, California from colon cancer at age 56. The material I read described Odets on his deathbed. (Recall that the fantasy I reported at the therapy session on February 5 involved Beethoven on his deathbed.) The text I read aloud described Odets' final days. Coincidentally, both Beethoven and Odets died at age 56. Odets had idolized Beethoven throughout his life and considered writing a play about the composer. While I was reading aloud to Dr. Palombo the reference to Odets' death at age 56, I interrupted myself and said, in a shock of recognition: "That's the same age as you! You're fifty-six years old!"

The Dream of Beethoven

Beethoven and I are alone in a room. We talk about music. I feel awe, enthrallment and narcissistic elation talking to Beethoven. I ask him what he plans to write after the series of string quartets he's working on. I feel sadness because I know that in fact Beethoven died after he completed his late string quartets. I know that he will not write any more music. He tells me that he has not decided what he will write after he completes his series of quartets. He tells me that he will never write another symphony, piano sonata, or string quartet. I suggest that maybe he will write something in variation form. He says, "perhaps." He then launches into a long technical discussion about the variation form. I don't understand anything that he says but I listen with keen interest. I then say, "People say that every musical form you tackle, you seem to exhaust. Your compositions are such a comprehensive statement in every form you write that you leave nothing for the composers who will follow you. You say everything there is to

say.” Beethoven responds, “I have heard that. I don’t believe it. Composers who come after me will write symphonies, piano sonatas and string quartets.”

(Beethoven was deaf from about the age of 35 onward; he couldn’t hear anything).

EVENTS OF THE PREVIOUS DAY:

1. I had a session with my psychiatrist, Dr. Shreiba in the late afternoon of December 12, 2013. I attempted to say something about Beethoven (“Sunday is Beethoven’s birthday”), but Dr. Shreiba cut me off, “Maybe we’ll get to that later.” Perhaps my feeling of being cut off by the psychiatrist corresponded to Beethoven dying relatively young at the age of 56. Beethoven’s life was cut short before he completed his life’s work, while he still had something to say. In this sense Beethoven symbolized my ideal self.

But we can show that Beethoven was also the hated father. Does the dream figure of Beethoven not provide a key to understanding the transference? Beethoven was deaf. Am I not saying that Dr. Shreiba was deaf to me, just as my parents were deaf to me? I suffered from not being “heard” by my parents. The dream represents my parents, perhaps especially my father, both as the wielder of powerful and inscrutable words — words that have a tremendous effect on me but are beyond my understanding at times — and also as one who is deaf to me. Beethoven as well as my parents are non-listeners, non-comprehenders: they filtered anything I said through an ideal image that they imposed on me, blocking out my actual self. My parents had self-serving expectations of me that they demanded to see fulfilled, at my expense. See, Martens, L., “Framing an Accusation in Dialogue: *Kafka’s Letter to His Father* and Sarraute’s *Childhood*.”

In transforming my therapist, Dr. Shreiba into an idealized object, that is,

Beethoven, was I not in fact disguising (or censoring) a bitter accusation against him that was occasioned by his act, earlier in the day, of cutting off my comment about Beethoven's birthday? Was I not saying in the dream: "*Talking to you is like talking to a deaf person! You don't hear a thing I tell you!*" Perhaps the strategy of the dream work was comparable to the rhetorical device of disguising a harsh criticism through imaginary dialogue. Cf. Martens, L., "Framing an Accusation in Dialogue: *Kafka's Letter to His Father* and *Sarraute's Childhood*."

I spent the therapy session on December 12, 2013 talking about the topic of narcissistic elation. "Narcissistic elation" was a term used by Béla Grunberger to highlight 'the narcissistic situation of the primal self in narcissistic union with the mother'. The term was coined to describe the state of prenatal beatitude, which according to Grunberger characterizes the life of the fetus: a state of megalomaniacal happiness amounting to a perfect homeostasis, devoid of needs or desires. The ideal here is bliss experienced in absolute withdrawal from the object and from the outside world. Narcissistic elation is at once the memory of this unique and privileged state of elation; a sense of well-being of completeness and omnipotence linked to that memory, and pride in having experienced this state, pride in its (illusory) oneness. Narcissistic elation is characteristic of an object relationship that is played out, in its negative version, as a state of splendid isolation, and, in its positive version, as a desperate quest for fusion with the other, for a mirror-image relationship (i.e., a relationship with an idealized other). It involves a return to *paradise lost* and all that is attached to this idea: fusion, self-love, megalomania, omnipotence, immortality, and invulnerability. Narcissistic elation may subsequently be reactivated within a therapeutic context. Edmund Bergler wrote of 'the narcissistic elation that comes from self-understanding' (i.e., as through psychoanalysis); while Herbert Rosenfeld described what he called the re-emergence of "narcissistic omnipotent object relations" in the clinical

situation'.

2. Dr. Shreiba had practiced psychiatry in Vienna, Austria for twenty years. Beethoven's funeral was held in Vienna in March 1827.
3. Earlier in the day I had an appointment with the nurse practitioner who prescribes my psychiatric medications. At the consult she said to me, "You have no friends." At Beethoven's funeral, the composer's friend Franz Grillparzer gave a funeral oration which contains an observation that I have long identified with: "He fled the world because he did not find, in the whole compass of his loving nature, a weapon with which to resist it. He withdrew from his fellow men after he had given them everything and had received nothing in return. *He remained alone because he found no second self (i.e., a 'mirror-image object.)*" The quest for such a mirror-image object is an aspect of narcissistic elation. It is estimated that from 20,000 to 30,000 people attended Beethoven's memorial service. Beethoven had achieved fame.
4. On December 10, 2013, I had posted the following quote from President Obama's speech at the memorial service in South Africa for Nelson Mandela. The memorial service was held in a sports stadium; thousands attended:

"Mandela showed us the power of action; of taking risks on behalf of our ideals. Perhaps Madiba was right that he inherited, 'a proud rebelliousness, a stubborn sense of fairness' from his father. Certainly he shared with millions of black and colored South Africans the anger born of 'a thousand slights, a thousand indignities, a thousand unremembered moments . . . a desire to fight the system that imprisoned my people.'" The quotation highlights Mandela's stubbornness and rebelliousness.

5. On December 12, 2013 I learned that the sign language interpreter

assigned to interpret the public speakers at Nelson Mandela's memorial service was a fake. He was an alleged schizophrenic whose signing, according to those knowledgeable about signing, was gibberish. Perhaps the "deaf" schizophrenic at Mandela's memorial service reminded me of the deaf Beethoven.

6. In the evening of December 12, 2013 I posted a biographical YouTube video about Beethoven on my blog. The video is titled, "The Rebel," and talks about Beethoven's social isolation, his rebelliousness, his desire for fame, and his stubbornness. That evening I also did some research on the Internet and discovered that according to the Meyers-Briggs Personality classification system, Beethoven would be classified as INTJ. This created a sense of identification for me since I have taken the Meyers-Briggs test and also scored INTJ. I may have registered the notion that Beethoven and I were mirror-image objects.

In many ways the INTJ personality is similar to the introjective depressive. The INTJ's primary mode of living is focused internally, where he takes things in primarily via intuition. His secondary mode is external, where he deals with things rationally and logically. INTJs live in the world of ideas. They value intelligence, knowledge, and competence, and typically have high standards in these regards, which they continuously strive to fulfill. To a somewhat lesser extent, they have similar expectations of others. INTJs focus their energy on observing the world, and generating ideas and possibilities. Their mind constantly gathers information and makes associations about it. INTJs are driven to come to conclusions about ideas. INTJs spend a lot of time inside their own minds, and may have little interest in the other people's thoughts or feelings. They may have problems giving other people the level of intimacy that is needed. Incidentally, the Meyers-Briggs personality test is used by 80% of Fortune 500 companies in making personnel decisions.

Additional Thoughts about My Sense of Awe

Awe is the feeling of wonder and astonishment experienced in the presence of something novel and difficult to grasp—a stimulus that cannot be accounted for by one's current understanding of the world.

Prototypical elicitors of awe include panoramic views, works of great art, and others' remarkable accomplishments. This positive emotion serves to facilitate new schema formation in unexpected, information-rich environments. Griskevicius, V. "Influence of Different Positive Emotions on Persuasion Processing:A Functional Evolutionary Approach."

The Dream of Beethoven expresses feelings of awe: "Beethoven and I are alone in a room. We talk about music. I feel awe, enthrallment and narcissistic elation talking to Beethoven." In the dream I find myself in the presence of something that is novel and difficult to grasp: "He then launches into a long technical discussion about the variation form. I don't understand anything that he says but I listen with keen interest."

Might we understand these feelings better? Might we look for the antecedents of these feelings in my early relationship with my mother? And, quite intriguingly, might there be a relationship between, on the one hand, my search in adulthood for a person who can serve as the object of my feelings of awe, and, on the other, my severe criticisms of, or "attacks on," my therapist?

The following is an excerpt from a paper by Judith L. Mitrani, Ph.D.: "Unbearable Ecstasy, Reverence and Awe, and the Perpetuation of an 'Aesthetic Conflict'." Dr. Mitrani is Training and Supervising analyst of The Psychoanalytic Center of California in Los Angeles.

The psychoanalyst Wilfred Bion describes a patient whose attacks on him in analysis, which centered on the patient's feelings of disappointment and hostility, did not constitute an attack on the "good breast" or the analyst's good interpretations. Neither did Bion seem to see the patient's fragmented presentation as the result of an envious attack on thinking or on the links that might have rendered his communications meaningful and relevant. Instead, Bion appears to conclude that his patient was attempting to have an experience of an object who might be able to understand and transform the inchoate experiences of the as-yet-unintegrated-baby-he and was therefore seeking the realization of his preconception of an object who could contain these experiences as well as his innate capacity for love, reverence, and awe.

Did the Dream of Beethoven express my struggle to find the realization of my preconception of an object who could contain my experiences of ecstasy, reverence, and awe?

Dr. Mitrani writes: **"Reverence and Awe versus Idealization.** In a paper read at a scientific meeting of the Los Angeles Psychoanalytic Society in 1967, Bion described an encounter with one patient who came to him after a previous analysis from which he had benefited, but with which he was nonetheless dissatisfied. At first Bion expected to find greed at the bottom of this patient's distress, but it soon became clear to him that there was something else going on.

Bion described his patient's outpourings, which were so fragmented "that they would have required an omniscient analyst to sort out and make sense of." Bion's interpretations were either labeled 'brilliant' or they were met with extreme disappointment and hostility to the point of depression. He finally concluded that:

There is a great difference between idealization of a parent because the child is in despair, and idealization because the child is in search of an outlet for feelings of reverence and awe. In the latter instance the problem centers on frustration and the inability to tolerate frustration of a fundamental part of a particular patient's make-up. This is likely to happen if the patient is capable of love and admiration to an outstanding degree; in the former instance the patient may have no particular capacity for affection but a great greed to be its recipient. The answer to the question – which is it? – will not be found in any textbook but only in the process of psycho-analysis itself.

In his customary style, Bion avoids saturating his concepts, leaving them somewhat ambiguous, and thus allowing us the freedom to use our own capacity for 'imaginative conjecture' to fill in the blanks, so to speak. I will yield to the temptation to do so with the understanding that the reader may draw his or her own conclusions, which may very well differ from my own.

I think Bion seems to be saying that, in this instance, he had met with a patient for whom Melanie Klein's theory of envy did not apply. Indeed he seems to be making it clear that he did not see his patient's disappointment and hostility as constituting an attack on the good breast or the analyst's good interpretations. Neither did he seem to see the patient's fragmented presentation as the result of an envious attack on thinking or on the links that might have rendered his communications meaningful and relevant. Instead, Bion appears to conclude that his patient was attempting to have an experience of an object who might be able to understand and transform the inchoate experiences of the as-yet-unintegrated-baby-he and was therefore seeking the realization of his preconception of an object who can contain these experiences as well as his innate capacity for love, reverence, and awe.

I would put forward here that the containing capacity, initially found and

felt to be located in this type of external object – when introjected – leads to the development of an internal object capable of sustaining and bearing feelings of ecstasy and love; an object that might form the basis of the patient's own self-esteem. This aim certainly calls for an analyst who truly thinks well enough of himself and his own goodness that he is not dependent upon the goodness and cooperativeness of the patient in order for such a positive self-perception to be confirmed, and in order for him to continue to function analytically.”

Now, I acknowledge that this book contains numerous speculations about my innate greed. But Bion's observations offer an avenue of thought regarding my dispositional awe and its possible connection to my idealization of some people.

Reflections of a Solitary on a Snowy Afternoon in January

So last week, at our last session, I don't know if you remember, it was snowing lightly and you pointed out the window and asked me what the snow reminded me of as I walked over here today.

—*Therapy Session on February 5, 2019*

So at about 6:30 PM my mother and I trudged off in the blizzard to the mall. And, you know, the storm was even worse now than it had been earlier. And there were really bad winds. Every footstep was a chore in the deep snow. We were concerned the whole time about getting to Gimbel's before it closed. It closed at 9:00 PM and if we didn't make it on time, the whole trip would have been in vain. I couldn't see how we could get there if every single step took so much work.

—*Therapy Session on January 22, 2019*

And my mother told me that there was a lot of bleeding. She said she was afraid I would bleed to death. And I'm guessing that is part of why this was traumatic for me is that I internalized my mother's panic. . . . I have no idea how my mother got me to the doctor's office. My parents didn't own a car. They didn't drive. Maybe my mother took a cab. I don't know. Is it possible my mother was in a panicked state the entire time on the way to the doctor's office? I have no idea.

—*Therapy Session on January 22, 2019*

I feel like I am a customer in a taxi cab and you're the driver. I depend on you to get me where I need to go, but you depend on me for directions. I have feelings of desperation about this – as if I will never get to the destination, as if my life depended on my getting to the destination.

—*Therapy Session in 2019*

Years ago, in January 2005, I wrote the following essay that was inspired by a two-day snow storm that I witnessed. The essay is based on the work of various authors—Jane Hamilton, Marya Hornbacher, Edith Wharton, Primo Levi, Boris

Pasternak, Henry David Thoreau, and the psychoanalysts Margaret Brenman-Gibson and Stanley Greenspan—that I synthesized. The essay is in the form of a letter to an imaginary friend, a doppelgänger.

The essay points to the significance of the snow-storm-as-metaphor in my mental life. At the therapy session on January 29, 2019 my therapist emphasized the idea that snow storms triggered comforting, nostalgic memories of my mother. Well, lo and behold, fourteen years earlier, in January 2005, I had written the following ten-page essay about a snow storm and it contains no consoling thoughts about my mother, but it may contain veiled allusions to trauma.

The analytic significance of the essay becomes clear when one reviews the following excerpts from the text:

- My entire existence, in some sense, can be viewed as the lived aftermath of *an accident*, or series of accidents ~ a fall from grace. I used to think if you fell from grace it was more likely than not the result of one stupendous error or else *an unfortunate accident*.
- Put another way, I need a therapist who understands the structure of my ego — my psychic terrain, one might say — and whose map of that structure will permit me to arrive home safely on a snowy, winter afternoon. Someone who knows which roads are navigable, which ones are temporarily blocked, and which roads are permanently impassable. There is nothing more frustrating to a passenger riding in a winter storm than the driver's self-aggrandizing false promises: promises about the ease of travel along a particular road that are based on the driver's foolhardy failure to appreciate the severity of the road conditions.

It is striking and psychoanalytically intriguing that at a recent therapy session in 2019 I spontaneously created a metaphor about riding in a taxi cab that is virtually identical to the 2005 metaphor above about "a passenger riding in a winter storm." But in the 2019 metaphor I associated to an event from childhood

to which I attributed significance. To paraphrase my former therapist, the psychoanalyst Stanley R. Palombo, M.D.: I had consciously substituted a metaphor about my current distressed mental state—my desperate concern that psychotherapy was not helping me arrive at my destination—with memories of past events of equal affective significance. By retracing the substitutions, one can see how a current conflict relates to childhood experience. See Palombo, S.R., “Day Residue and Screen Memory in Freud’s Dream of the Botanical Monograph.”

At a therapy session in 2019 I analogized my therapist to a taxi driver and analogized myself (as patient) to a passenger in the taxi who was desperate to get to his destination: “I feel like I am a customer in a taxi cab and you’re the driver. I depend on you to get me where I need to go, but you depend on me for directions. I have feelings of desperation about this – as if I will never get to the destination, as if my life depended on my getting to the destination.” [Compare the metaphor above from 2005 about riding through a snow storm]. I thought about the fact that at age 2 and a half I suffered an injury that my mother thought was life threatening. My pediatrician was on vacation and he had referred his patients to another doctor. Did my mother have feelings of panic about getting me to the doctor? Did I internalize that panic?” 1/

1/ Feelings of despair about reaching a longed-for destination might relate to the existential trials of the creative individual. I am reminded of Erik Erikson's observations about Freud's anguish in mid-life about completing his psychoanalytic project: "Freud at times expressed some despair and confessed to some neurotic symptoms which reveal phenomenological aspects of a creative crisis. He suffered from a 'railroad phobia' and from acute fears of an early death—both symptoms of an over-concern with the all too rapid passage of time. 'Railroad phobia' is an awkwardly clinical way of translating *Reisefieber*—a feverish combination of pleasant excitement and anxiety. But it all meant, it seems, on more than one level that he was 'coming too late,' that he was 'missing the train,' that he would perish before reaching some 'promised land.' He could not see how he could complete what he had visualized if every single step took so much 'work, time and error.' Erik H. Erikson, *Insight and Responsibility.*

Is it possible that the metaphor I created in 2019 about my desperate ride in a taxi cab is not a metaphor at all, but, in fact, a concrete representation of a real event from childhood: does the metaphor relate to my ride with my mother to the doctor's office at age two-and-a-half to treat an injury to my mouth—resulting from an accidental fall ("an unfortunate accident")—that my mother believed was life threatening?

I don't want to overplay the significance of this childhood physical trauma. It is important, rather, to view the trauma as psychologically related to several issues, namely, early separation-individuation, unconscious conflict, and depressive traits that are all operative in my character. Cf. Blum, H.P. "Picasso's Prolonged Adolescence, Blue Period, and Blind Figures" (exploring early issues of separation-individuation, unconscious conflict, trauma, and depression revived and reworked in Picasso's turbulent protracted adolescence).

Dear Friend,

I weathered the snow storm on Saturday, and spent the winter day in my room, while the snow whirled wildly without, and even the traffic noises were hushed. I occupied the day with Mr. Frost together with a host of other authors who populated my imagination as welcome guests: Jane Hamilton, Marya Hornbacher, Edith Wharton, Primo Levi, Boris Pasternak, Henry David Thoreau, and Margaret Brenman-Gibson. Stanley Greenspan was here too. But then, Dr. Greenspan is always here; he holds the key to my inner world, and he comes and goes at will. Oh, and lest I forget, Lord Byron visited briefly to convey a unique message "To Ellen."

In my loneliness I become a spectator. My imagination leads a procession of living creatures before me. I watch and listen to these guests of my imagination as I would a performance at the theater. And at times these

fantastic creations of my inner world seem more real than reality itself. I may be affected by a theatrical exhibition; on the other hand, I may not be affected by an actual event which appears to concern me much more. I only know myself as a human entity; the scene, so to speak, of thoughts and affections; and am sensible of a certain doubleness by which I can stand as remote from myself as from another. However intense my experience, I am conscious of the presence and criticism of a part of me, which, as it were, is not a part of me, but a spectator, sharing no experience, but taking note of it, and that is no more I than it is you. When the play, it may be the tragedy, of life is over, the spectator goes his way. It was a kind of fiction, a work of the imagination only, so far as he was concerned. This doubleness may easily make us poor neighbors and friends sometimes.

I came across a poem of Robert Frost's that seemed especially appropriate: "Brown's Descent." The opening lines read: "Brown lived at such a lofty farm that everyone for miles could see his lantern where he did his chores in winter after half-past three. And many must have seen him make his wild descent from there one night, 'cross lots, 'cross walls, 'cross everything describing rings of lantern-light. Between the house and barn the gale got him by something he had on and blew him out on the icy crust that cased the world, and he was gone!"

My own life is like an unending slip and slide; I seem to be continually at the edge of an abyss, mere seconds and a few feet from swerving involuntarily into oncoming traffic. I fear crashing into the traffic in the opposite lane, hurling into the windshield ~ hurting myself and damaging the rearview mirror.

My entire existence, in some sense, can be viewed as the lived aftermath of an accident, or series of accidents ~ a fall from grace. I used to think if you fell from grace it was more likely than not the result of one stupendous error or else an unfortunate accident. I hadn't learned that it can happen so gradually you

don't lose your stomach or hurt yourself in the landing. You don't necessarily sense the motion. I've found it takes at last two and generally three things to alter the course of a life: You slip around the truth once, and then again, and one more time, and there you are, feeling, for a moment, that it was sudden, your arrival at the bottom of a snowdrift.

That's the way I feel now. I feel as if I'm at the bottom of the heap, struggling to ascend from the snowdrifts that ensnare me in a winter wasteland.

At this moment, the problem is compounded by a writer's block. I feel I'm straining for something to say, something to express. I feel immobile, locked in the grip of a creative and emotional deep freeze.

There is a stillness without and a confused tumult within. I gaze out my window. I seem a part of the mute melancholy landscape, an incarnation of its frozen woe, with all that is warm and sentient in me fast bound below the surface; but there is nothing unfriendly in the silence. The silence is a balm for my inner disquiet. I simply feel that I live in a depth of moral isolation too remote for casual access, and I have the sense that my loneliness is not merely the result of my personal plight, tragic as it is, but has in it, as I've hinted many times before, the profound accumulated cold of many stark and harshly-demanding winters.

The night following the storm was perfectly still, and the air so dry and pure that it gave little sensation of cold. The effect produced on me was rather a complete absence of atmosphere, as though nothing less tenuous than ether intervened between the white earth and the gray sky above.

I let the vision possess me as I contemplated what to write to you. I am never so happy as when I abandon myself to these epistolary dreams. A wave of warmth goes through me as I think about the fact that for me the act of writing is the prolongation of a vision.

Saturday night. I set about to write. I scribbled some notes in longhand. What I wrote that night fell into two parts. Clean copies ~ improved versions of earlier scribbling ~ were set out in my best penmanship. New work was written in an illegible scrawl full of gaps and abbreviations. In deciphering these scribbles, I went through the usual disappointments. Last night these rough fragments had moved me, and I myself had been surprised by some felicitous passages. Now these very passages seemed to me distressingly and conspicuously strained.

The passages didn't flow. A clear and pleasing narrative did not materialize. I felt torn between a fevered urgency and a bitter languor. I cannot blame my inner censor for the block; that censor, like a good psychoanalyst, contemplated my outpourings with evenly-hovering attention. The ideas were there all right, but they failed to materialize into a cohesive communication. I not only feel that I am incomprehensible to others; I am sometimes incomprehensible to myself as well. There were many false starts ~ and jarring stops. It was like driving through a winter storm. My thoughts made slow headway, and a vague fear gripped me as I envisioned veering off a train of thought or, alternatively, into a jarring wreck of incompatible ideas. The driver in a winter storm strives vigilantly for a commodious path, and is dismayed when he finds how far, after a seemingly interminable ride, he still remains from home.

It has been the dream of my life to write with an originality so discreet, so well concealed, as to be unnoticeable in its disguise of current and customary forms; all my life I have struggled for a style so restrained, so unpretentious that the reader or the hearer would fully understand the meaning without realizing how I assimilated it. I strive constantly for an unostentatious style, and I am dismayed to find how far I still remain from my ideal.

Saturday evening I had tried to convey, by words so simple as to be almost

childish and suggesting the directness of a poem, my feelings of mingled idealism and fear and longing and courage, in such a way that should speak for itself, almost apart from the words.

Looking over my rough sketches now, I find that they needed a connecting theme to give unity to the lines, which for lack of it fell apart.

I take a break from my writing, and look out the window. I peer closely and inquisitively at the flakes of snow on the window ledge. Each crystal flake has an individual identity. Like a poem, each flake speaks of itself alone in a lyrical manner. Each six-sided flake expresses its own self in a broad, spacious hexameter. The regularity of the rhythm, independent of the meaning and inherent in the meter itself, does not strike me as doggerel; rather it contains a unique message expressed in infinite variety within a set form. Variety of expression within a strict form is difficult but engaging; the structural exigencies of poetry obviate verbosity just as nature imposes simplicity of form on the snowflake as a hedge against crystalline "windiness." The snowflake exalts in the concise and strong. It describes itself with the greatest rigor and the least clutter. The snowflake is compact, discrete; it is delineated by neat boundaries. Its individual identity is secure. The snowflake is a paradigm of firm, but precarious, self-delineation. Time and temperature will soon conspire to fuse the individual snowflakes into a crust amounting to a loss of individual identity.

Like the narrative of the psychoanalytic patient, every detail of the snowflake's form, however trivial, has a meaning. In the snowflake each crystalline projection has a structural function just as the analytic patient's outpourings follow narrative necessity.

The patient expresses his thoughts with clinical parsimony. In psychoanalysis the preferred explanation for a series of symptoms tends to be cast in terms of single events from the patient's past rather than

different events on different occasions. The single event may be repeated again over time but the form of the event tends not to change. Similarly, nature endows each snowflake with an economy of expression within a hexagonal form.

The flake makes you think of something solid, stable, well-linked. In fact it happens also in crystallography as in architecture that "beautiful" edifices, that is symmetrical and simple, are also the most sturdy; in short the same thing happens with the crystal as with cupolas of cathedrals, the arches of bridges, or the well-designed theater whose structure follows the demands of acoustical science. And it is also possible that the explanation is neither remote nor metaphysical; to say "beautiful" is to say "desirable," and ever since man has built he has wanted to build at the smallest expense and in the most desirable fashion, and the aesthetic enjoyment he experiences when contemplating his work comes afterward. Certainly, it has not always been this way: there have been centuries in which "beauty" was identified with adornment, the superimposed, the frills; but it is probable that they were deviant epochs and that the true beauty, in which every century recognizes itself, is found in the upright stones of a simple farmhouse or the blade of the farmer's ax.

Early Saturday afternoon I looked out my window. The old park ~ or what remains of it ~ came right to the tool shed, as if to peer at my face and remind me of something. The snow was already deep. It was piled high on the tool shed. Snow hung over the edge of the shed, like the rim of a gigantic mushroom. A solitary raven was perched on the roof devouring, in Lord Byron's words, "the yellow harvest's countless seed." For a moment the bird freezes in an upright position, fixed like a stage prop suspended in time. The world stops.

Although it was early afternoon and full sunlight, I felt as if I were standing late at night in the dark forest of my life. Such was the darkness of my soul, such was my dejection. The new moon shining almost at eye

level was an omen of separation and an image of solitude.

I paused and reflected. My mind wandered. Thoughts and images emerged unbidden as I contemplated the blinding whiteness of the snow. A mirage appeared, as a thought out of season. I was in Bayreuth, Germany, in January. The tool shed directly across from my apartment window appeared to me as a chimera; it was Wagner's Festival Theater in mid-January, six months before the summer opera festival will begin. The theater has fallen into its customary winter disuse. As for the out-of-season festival theater ~ a "beautiful" edifice of magnificent symmetry and noble and imposing forms ~ on a lofty hill outside the town, when there was only the falling snow to be seen and the auditorium was bare, comfortless, and shadowy, it felt to me less like a place of high art and pleasure than a vacant library that had closed early on a snowy January day ~ or, perhaps, a New England barn, atop a hill that everyone for miles can see.

The mirage seemed to give the appearance of a somewhat arcane sensation, a suggestion of something simultaneously flaunted and guarded, a sort of a private delusion waiting to be revealed. Through the charms and simplicities of Bayreuth, during the months before the summer festival, the image of Richard Wagner perpetually looms, like an icon or an ideal ~ the comforting presence of an imagined friend, perhaps ~ and in my fancy left my mirage of Bayreuth in a condition of half-bewitched expectancy. Just you try putting Wagner out of your mind in Bayreuth ~ even in January! Wagner became in this moment a symbol of All-Things-wished-for but denied: an embodiment of frustrated enticement. He became a symbol of the special friend one despairs of ever finding. I recognized my emotional emptiness in the phantasm of the out-of-season, vacant theater at Bayreuth. And then, in a moment the image of Wagner that had gripped my fantasies disappeared, as if it had been blown out on the icy crust that cased the world, and he was gone!

I was left with a spiritual hunger borne of a disconnected feeling. The

disconnected mood which strains for closure more in the artist than in others is the same bridge that joins me to Victor Hugo's "miserables." My emotional starvation welcomes as a brother fellow seekers: idealistic souls who pursue an inner vision of truth and meaning in defiance of the compact majority. But my starvation, however painful, also aids me in that central necessity for any artist ~ to find a communicative Form or structure whereby I can simultaneously heal my inner disconnections and end my disconnection from others. My gift ~ if it be called a gift ~ permits me, while integrating the contrarities within, to provide such integration for my audience as to unite me with it. This is the self-healing and other-healing function of all art.

It is only by writing these letters that I seem able to derive any satisfaction from life. Social avenues of engagement with others seem blocked by the barrenness of my frozen soul. I am forever locked in the grips of a slippery slope that I desperately want to ascend, but to which I ~ like Camus's Sisyphus ~ am forced to submit in fatal descent. I lack the capacity for true engagement with others, and so I occupy myself with an imaginary connection with a distant and unseen audience through the communicative form of these letters.

For the genuine artist, the search for a suitable form competes in importance with the need to express a particular content. Mere content alone veers toward dissolution and incomprehensibility in the absence of a unifying structural barrier or boundary.

Structural issues of a different kind also mediate social relatedness, for, as Erik Erikson has observed, true engagement with others is the result and the test of firm self-delineation. Where this is still missing, the individual when seeking tentative forms of friendship is apt to experience a peculiar strain, as if such tentative engagement might turn into an interpersonal fusion amounting to a loss of identity, and requiring, therefore, a tense inner reservation, a caution in commitment. Because I myself have never

resolved this strain I isolate myself and enter, at best, only stereotyped and formalized interpersonal relations. For where an assured sense of identity is missing even friendship becomes a desperate attempt at delineating the fuzzy outlines of identity by mutual narcissistic mirroring: to make a friend then often means to fall into one's mirror image, hurting oneself and damaging the mirror.

I seek a real person, an actual other, a comrade-in-arms ~ a psychical ballast, as it were ~ with whom I can share my thoughts and feelings.

If I can't make a friend, I would hope I might find a therapist with whom I could communicate: someone whose opinions I can respect, someone who might offer narcissistic nourishment to ease my emotional starvation. But at the moment there is no one.

What I desperately need at this time is a therapeutic process, including a transference relationship and the skillful guidance of a seasoned therapist to avail myself of opportunities for new growth: someone who can appreciate the needs, limitations, and capacities associated with my ego structure. What I need is a therapist who has a road map of the structural components of my ego processes to go alongside a road map of intrapsychic content (e.g., wishes, conflicts, fears), that can increase my understanding of my Self and improve my day-to-day adjustment.

An important fact: I grew up in the theater. My parents were actors and directors, and I myself began performing when I was just a child. There is no place on earth that fosters narcissism like the theater, but by the same token, nowhere is it easier to believe that you are essentially empty, that you must constantly reinvent yourself in order to hold your audience in thrall. In childhood I became fascinated with transformations, with mirage and smoke and mirrors (rearview or otherwise). Perhaps a genetically less sensitive, less porous, and less gifted youngster would have responded with greater resilience to his family and would have achieved a

more comfortable day-to-day adjustment. But I was hypersensitive to the goings-on in my family, and my early life in the theater exacted its toll.

I need a therapist who has a rich understanding of the various dramas played out in my intrapsychic life. I need a therapist who will sit quietly as he watches the play unfold, while being in his or her own mind also a co-actor. I need a therapist who appreciates the psychodrama of therapy: one who, within the walls of his office, is able to surrender his identity to the phantoms that haunt his patients, continually attending to the form of the moment of communication while bearing in mind the whole session as it echoes and repeats the form of the patient's life drama. I require a therapist who can accommodate the multifarious diffusion of my identity ~ my inner gallery of characters ~ and who can surrender himself to the act of witnessing the entire process of my inner drama play out.

Put another way, I need a therapist who understands the structure of my ego ~ my psychic terrain, one might say ~ and whose map of that structure will permit me to arrive home safely on a snowy, winter afternoon. Someone who knows which roads are navigable, which ones are temporarily blocked, and which roads are permanently impassable. There is nothing more frustrating to a passenger riding in a winter storm than the driver's self-aggrandizing false promises: promises about the ease of travel along a particular road that are based on the driver's foolhardy failure to appreciate the severity of the road conditions.

It's especially important clinically to understand the structure of the ego, in addition to the particular dynamic phenomenon the ego is struggling with at any moment so that therapist and patient can knowledgeably journey across the patient's mental landscape: to observe the patient's wishes and abstracted feeling states, make connections between different wishes and feelings (as well as different sides of a conflict), and understand these in historical, current, and future contexts.

Be that as it may.

It is now early evening on this snowy day in mid-January. The storm has all but passed. The stir is over. I step forth once again to peer outside my window. I strain to make the far-off images beyond my windowpane yield a cue to the events that may come in the days ahead. Night and its murk transfix and pin me, staring through thousands of stars. I cherish this moment, this rigorous conception of a snowy winter evening, and I consent to play my part therein as spectator. But another play is running at this moment, so, for the present, I seek a premature release. And yet, the order of the acts has been schemed and plotted, and nothing can avert the final curtain's fall. The January thaw will soon take off the polish of the snow's crust. I bow with grace to natural law. I stand alone. All else is swamped in fuzzy dissolution. To live life to the end, while peering back to the path one has already traversed, is not a childish task.

Till my next letter, Friend!

Note about Hamlet and Hamlet

At a therapy session I talked about having had a problematic relationship with my mother and, on some level, a fantasy idealized relationship with my father. At a later point, in a seeming digression, I said to my therapist, “Let me read to you a paragraph of a creative piece I wrote in January 2005.” The text I read was the concluding paragraph of the creative piece, “Reflections of a Solitary on a Snowy Afternoon in January.”

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release. And yet, the order of the acts has been schemed and plotted, and nothing can avert the final curtain's fall. The January thaw will soon take off the polish of the snow's crust. I bow with grace to natural law. I stand alone. All else is swamped in fuzzy dissolution. To live life to the end, while peering back to the path one has already traversed, is not a childish task.

In fact, the paraphrase I read was a reworking of Boris Pasternak's poem, "Hamlet," part of a collection of poems included in Pasternak's novel, *Dr. Zhivago*.

After I finished reading my paraphrase of Pasternak's poem, I said to my therapist, in a shock of recognition: "I'm Hamlet! This is a paraphrase of Pasternak's poem 'Hamlet.' Hamlet had a disturbed and unsatisfying relationship with his mother, while his idealized father is absent from the action — Hamlet's father appears as a ghostly revenant, a mere memory or idea in Hamlet's mind."

Pasternak's Poem "Hamlet"

The stir is over. I step forth on the boards.
Leaning against an upright at the entrance,
I strain to make the far-off echo yield
A cue to the events that may come in my day.

Night and its murk transfix and pin me,
Staring through thousands of binoculars.
If Thou he willing, Abba, Father,
Remove this cup from me.

I cherish this, Thy rigorous conception,
And I consent to play this part therein;
But another play is running at this moment,
So, for the present, release me from the cast.

And yet, the order of the acts has been schemed and plotted,
And nothing can avert the final curtain's fall.
I stand alone. All else is swamped by Pharisaism.
To live life to the end is not a childish task.

The poem's narrator, an actor standing on stage, is simultaneously the character Hamlet as well as the actor playing Hamlet, as if each was a metaphor for the other. This plays upon the fact that the character Hamlet was also an actor.

You will recall that the creative piece, "Reflections of a Solitary on a Snowy Afternoon in January" includes the following paragraph, which can now be seen to link up with Pasternak's poem, "Hamlet." *The narrator of Pasternak's poem is simultaneously the character Hamlet as well as an actor playing Hamlet.* In my family I was simultaneously Gary Freedman as well as the "actor" playing Gary Freedman.

An important fact: I grew up in the theater. My parents were actors and directors, and I myself began performing when I was just a child. There is no place on earth that fosters narcissism like the theater, but by the same token, nowhere is it easier to believe that you are essentially empty, that you must constantly reinvent yourself in order to hold your audience in thrall. In childhood I became fascinated with transformations, with mirage and smoke and mirrors (rear view or otherwise). Perhaps a genetically less sensitive, less porous, and less gifted youngster would have responded with greater resilience to his family and would have achieved a more comfortable day-to-day adjustment. But I was hypersensitive to the goings-on in my family, and my early life in the theater exacted its toll.

It is noteworthy that Hamlet's respective relationships with his scorned, unempathetic mother and his idealized but unavailable (because dead) father parallel the dynamics of Kohut's case of Mr. U, which I cited several times in this book.

Mr. U turned away from the unreliable empathy of his mother and tried to gain confirmation of his self through an idealizing relationship with his father. The self-absorbed father, however, unable to respond appropriately, rebuffed his son's attempt to be close to him, depriving him of the needed merger with the idealized self-object and, hence, of the opportunity for gradually recognizing the self-object's shortcomings.

Kohut, H., *The Restoration of the Self*.

James Groves, M.D. has made a similar observation about the effect on Hamlet of having had an unempathic mother: "Not just Kleinian object relations theory but also [Kohut's] self-psychology shows the [closet] scene [in *Hamlet*] as pivotal; it sees the individual's main task as the development of a cohesive self. Unempathic parenting leaves behind fault lines that rupture under stress to become a fragmented self. When the child is used as a selfobject, the *parent's* 'mother,' the child is parentified. A child used as the selfobject of a parent is vulnerable to fragmentation. Hyman Muslin comes to this same formulation describing Hamlet's fragmentation into a 'self of despair' under stress; he sees Hamlet's use of Gertrude as a healing selfobject to repair himself, just as we are arguing." Groves, J. *Hamlet on the Couch: What Shakespeare Taught Freud*.

Postscript

I take leave of the reader at this point in our journey with thoughts about a dream I had a brief time after my therapist terminated our work. I believe the dream discloses my all-consuming desire for psychoanalysis as well as my feelings of frustration and unease with my therapist's non-analytic technique.

The Dream of the Borromean Islands

Upon retiring on the night of February 20, 2019, I had the following dream:

I am in a deeply wooded area. It resembles a picnic site. There is a lake and people are swimming in the lake. There are islands in the lake off to the distance in one direction. Off to another side of the lake there is what looks like an Egyptian temple, but it is just two supporting structures with a lintel (see picture above), as if it were a giant picture frame in the lake, the two sides of the frame and the top portion of the frame. I am intensely hungry. My sister is there and I say I am hungry for breakfast, tea with a piece of cake. I have a camera and I am taking pictures of the scene. It is a beautiful scene. A boy comes up to me and grabs the camera. He says to me, "I want that," referring to the camera. I am angered: "Everybody wants something from me," I think. There is a vague sense of anxiety throughout the dream. My sister seemed detached from the environment. It was as if she and I were having two different experiences in the very same environment. I was enthralled by my surroundings, but my sister seemed indifferent.

On February 12, 2019 I had my final therapy session. About a week later – the day following the dream (February 21, 2019) – I was scheduled to have my first session with a new therapist, a psychoanalyst. I was both intensely excited and anxious about seeing her.

On the day of the dream, February 20, 2019, I happened to watch the BBC news on television. A news story featured an interview of an Italian-born professor of theology affiliated with Villanova University, outside Philadelphia, my hometown. He discussed the sexual abuse scandal in the Catholic Church. The news story featured film footage of the Pope speaking to a crowd of people in Vatican Square from inside the Vatican.

1. In 1978 I took a trip to Italy. I visited the Vatican. On a Sunday I went to see the Pope speak to a large crowd in Vatican Square from his Vatican residence. I also visited Stresa, in the lake region in Northern Italy. Stresa sits on Lake Maggiore. In Lake Maggiore are the three Borromean Islands.

The Borromean Islands (*Isole Borromee*) are a group of three small islands and two islets in the Italian part of Lago Maggiore, located in the western arm of the lake. Together totaling just 50 acres in area, they are a major local tourist attraction for their picturesque setting.

I photographed the lake and the islands. I remember thinking, “This is one of the most gorgeous things I have ever seen.” My hotel room in Stresa overlooked Lake Maggiore. I remember watching the sunset over Lake Maggiore one evening; it was spectacular.

2. Villanova University is located in the western Philadelphia suburbs. I had been accepted to the LL.M. program in tax law at Villanova University in 1983. Also in the western Philadelphia suburbs is a Catholic seminary, St. Charles Borromeo Seminary. My mother mentioned that seminary several times.

3. The weekend of December 30-31, 1978, three months after my trip to Italy, I visited New York City. I stayed at a hotel over the weekend to see Wagner’s *Tristan und Isolde* and Strauss’s *Elektra*. I visited the Metropolitan Museum of Art where I viewed the Egyptian temple, The Temple of Dendur, located in the Sackler Wing (*see picture above*). The

Temple of Dendur had been a gift from the Egyptian Government to the United States, donated in 1967.

Thoughts:

The issue of corruption in the Catholic Church parallels my notion that my therapist, and the clinic that employed her, was corrupt; I viewed her work and the work of her clinic as “cult-like.” I saw her work as a form of brainwashing, not legitimate psychotherapy. I wanted to expose the corruption of my therapist in the letters I wrote about her the way the victims of sexual abuse exposed priests in the Catholic Church. But I also wanted to provide psychoanalytic insight into the themes that emerged in my therapy sessions: a psychoanalytic interpretation of my personality struggles that was ignored by my therapist. The letters I wrote about my therapy sessions were simultaneously an attempt to expose the “corrupt work” of my therapist and an attempt to demonstrate what a legitimate psychoanalytic inquiry of my personality would reveal. I am reminded of the work of Martin Luther who sought to unmask the corruption of the 16th-Century Catholic Church and simultaneously revive the original ideals of the founders of the Church. The Catholic Church, as an institutional structure, paralleled, in my mind, the mental health clinic where I obtained therapy. Both the Catholic Church and the Clinic had, I believed, a false self-image as benefactors (“givers”), when in fact, in my perception, they were both exploitive and corrupt.

I note that the theme of vacation seems prominent. The manifest dream takes place at a holiday site, and my associations to the dream relate to holiday trips I took in 1978 to New York City and Italy. The present dream parallels in important ways a previous dream in this book (*The Dream of Eggs and Lox*), which I associated with Freud and psychoanalysis and which also featured the theme of hunger.

You will recall that in the Dream of Eggs and Lox . . .

. . . I am in Atlantic City on vacation with my father. It is a Friday morning. I am very hungry. My father and I go to a restaurant in the inlet. The waitress says: "It's the end of the week. We have no food. We are waiting for a food shipment. I can serve you, but only one meal. One of you will have to go to another restaurant." My father and I sit at a table. My father is served an order of eggs and lox. I am angry with my father. I think: "Any other father would let his son eat the one meal and make the sacrifice of going hungry. Because I have a selfish father, I will have to go hungry." I think, "I have to have my blood drawn later, so at least, I will not have had a high fatty breakfast." I leave the restaurant and my father and take a walk alone on the boardwalk. I come to Vermont Avenue. My family used to stay at Vermont & Oriental every summer with friends of my father. The Vermont Avenue Apartments have been torn down and I have pangs of nostalgia. In their place have been built a large, modern apartment house. It is pleasing, but it just isn't the way I remembered Vermont Avenue. There are shops on the first floor. There are many tourists there. I said to one of the tourists, a woman: "The Vermont Avenue Apartments used to be located here." She said, "I didn't know that. I never saw that building." I said, "Did you see the movie Atlantic City? It starred Burt Lancaster. There was a shot of the Vermont Avenue Apartments in that movie." She said, "I never saw that movie." I walk on down Vermont Avenue, hoping to come to Oriental Avenue, to see the house where we used to stay. Everything has changed. All the buildings have been torn down. There are sand dunes everywhere with pine trees planted everywhere. I get lost.

Be that as it may.

The theme of wanting is overdetermined in the present dream. I am intensely hungry. This parallels the boy who wanted my camera; he was "hungry" for my camera. Does this state of wanting relate to the issue of envy, which is a state of wanting?

Does "the temple that looks like a picture frame" parallel the camera, a device that "takes pictures?" Does the dream image of taking pictures

with a camera symbolize my act of writing letters about my therapy sessions, which memorialize the interactions between me and my therapist and also elaborate psychoanalytic themes overlooked by my non-analytic therapist?

I associate to Penn State Abington, where I attended the first two years of college, which had a densely-wooded campus. At the center of the campus was a duck pond. It was delightful.

Is there a theme of my *wanting* (or *hungering for*) knowledge, *knowledge about myself derived from psychoanalysis*? Was this desire for knowledge related to my association to my college alma mater, Penn State? Was this desire for *wanting knowledge* also related to my association to the Catholic seminary? Did I not feel disappointment and unease with my therapist, who relied at times on cognitive-behavioral technique and who thereby thwarted my desire or hunger for self-knowledge?

In Kleinian theory, an infant whose *wanting* of the breast is frustrated transforms his fantasy of a “giving, bountiful breast” into a fantasy of a “bad breast,” that is, a frustrating or thwarting breast. In some sense, the infant whose desire for the giving breast is thwarted transforms his disappointment into a fantasy of a “corrupt” breast. Did the mental health clinic where I sought treatment symbolize the bad breast, the “corrupt breast,” that thwarted my desire for self-knowledge?

Freud associated ancient Egypt and its buried artifacts (symbolized in the dream by the royal Temple of Dendur) with psychoanalysis and the patient’s sequestered past as encoded in the unconscious. He viewed dreams, which he called the “royal road to the unconscious,” as the *key to* decoding the *locked box* of the patient’s unseen inner self. Indeed, Freud referred to his landmark book, *The Interpretation of Dreams* as the “Egyptian dream book.”

Perhaps in the dream my desired destination, psychoanalysis – the idealized, giving breast, which, in my view offered “great insightful wisdom” – was, figuratively speaking, “the other shore,” just as the dream image of the beautiful islands and the Egyptian royal temple were, in a literal sense, located on another shore. I was “this shore” – envious, hungry, unsatisfied, both as a therapy patient and as concretely represented in the dream.

I am reminded of a commentary on a Buddhist parable found in the *Diamond Sutra*.

What does paramita mean? It is rendered into Chinese by "reaching the other shore." Reaching the other shore means detachment from birth and death. Just because people of the world lack stability of nature, they find appearances of birth and death in all things, flow in the waves of various courses of existence, and have not arrived at the ground of reality as is: all of this is "this shore." It is necessary to have great insightful wisdom, complete in respect to all things, detached from appearances of birth and death—this is "reaching the other shore." It is also said that when the mind is confused, it is "this shore." When the mind is enlightened, it is "the other shore." When the mind is distorted, it is "this shore." When the mind is sound, it is "the other shore." If you speak of it and carry it out mentally, then your own reality body is imbued with paramita. If you speak of it but do not carry it out mentally, then there is no paramita.

Synthesis of Issues Relating to Attachment Style, Introjective Pathology, Defenses against Object Need, Twinship Fantasy, and Scapegoating with Special Reference to Kleinian Theory

In early childhood I struggled with food. I ate little and was seriously underweight. My parents continually fretted about my food refusal. My pediatrician told my parents when I was about three years old, “I’ve seen chickens fatter than him.” The doctor prescribed a tonic to stimulate my appetite; I recall that it was green in color and mint-flavored. My mother gave me a tablespoon of the tonic about an hour before dinner. I remember hating the tonic. I resisted being coerced into eating. My mother eventually realized that the tonic was ineffective, which gave me immense satisfaction. In my mind, I could now resume my food refusal. I had control.

A research study on anorexia nervosa states, applying a Kleinian analysis: “It appears that the anorexic is unconsciously motivated, at least partly, by her desire to repudiate any experience of dependency, separateness, loss, frustration, envy, fear, guilt and helplessness.” Gilhar, L., “A Comparative Exploration of the Internal Object Relations World of Anorexic and Bulemic Patients.”

These observations seem significantly related to my own fears of maternal engulfment as well as my dismissive avoidant attachment style. It has been found that anorexics have anxieties of being devoured; they fear loss of love, engulfment or of being consumed by the “evil” part. Further, anorexics have a need for separation, independence, control and protection from their “evil”, self-destructive parts and a need for containment. They also have a need for their own sense of control and escape from the controlling mother-figure. See Gilhar.

For the anorexic food is the symbolic equivalent of mother. The anorexic sees mother not as the provider of food but, symbolically, food itself. The anorexic attempts to separate from her mother and untangle her body from her mother's by not taking her in. Thus, what she plays out by not eating is an attempt to create the concept of a boundary between her body and her mother's. The reason why she can never express her separateness is because she fears the annihilation. The anorexic has intense fear of loss, thus, she is unable to ask for what she needs and accepts love in any form that it comes – food. The anorexic has an ambivalent relationship with food because there were such conflictual messages projected into it. See Gilhar.

Research confirms an association between dismissive avoidant attachment and anorexia. “[Dismissing avoidant] patients tend to maintain an avoidant, detached, or distanced position in relation to attachment. Such attitude implies the use of deactivation strategies in order to keep distressing emotions under control after attachment activation. This dismissing attitude represents a defensive turning away from potentially painful emotional material, similar to the anorexic’s denial of hunger. . . . The predominance of dismissing and unresolved adult attachment and analogous personality style groups (avoidant, fearful) in eating disorder samples is striking, especially for anorexia.” Delvecchio, E., “Anorexia and Attachment: Dysregulated Defense and Pathological Mourning.” I note that Westen identified a high-functioning, perfectionistic subpopulation of anorexics who resemble introjective depressives. These individuals tend to be conscientious and responsible; self-critical; set unrealistically high standards for themselves and are intolerant of own human defects; are competitive with others (whether consciously or unconsciously); expect themselves to be perfect; take pleasure in accomplishing things; and tend to feel guilty. Westen, D. and Harnden-Fischer, J., “Personality Profiles in Eating Disorders: Rethinking the Distinction Between Axis I and Axis II.” Like persons in this anorexia subpopulation, patients with introjective disorders are plagued by feelings of guilt, self-criticism,

inferiority, and worthlessness. They tend to be more perfectionistic, duty-bound, and competitive individuals, who often feel like they have to compensate for failing to live up to the perceived expectations of others or their own exacting standards. Blatt, S. J., & Shichman, S., "Two Primary Configurations of Psychopathology."

Like the individual with a dismissive avoidant attachment style the anorexic is able to survive her worst unacknowledged fear, namely, the loss of love and the object. In her anorexic world she feels powerful and self-sufficient, she feels omnipotent and in control of what goes in and out of her body. She attempts to negate her dependence on the object. Furthermore, she feels omnipotent in the face of death. See Gilhar. People with a dismissive style of avoidant attachment tend to agree with these statements: "I am comfortable without close emotional relationships", "It is important to me to feel independent and self-sufficient", and "I prefer not to depend on others or have others depend on me." People with this attachment style desire a high level of independence. The desire for independence often appears as an attempt to avoid attachment altogether. They view themselves as self-sufficient and invulnerable to feelings associated with being closely attached to others. They often deny needing close relationships. Some may even view close relationships as relatively unimportant. Not surprisingly, they seek less intimacy with attachments, whom they often view less positively than they view themselves. Investigators commonly note the defensive character of this attachment style. People with a dismissive-avoidant attachment style tend to suppress and hide their feelings, and they tend to deal with rejection by distancing themselves from the sources of rejection (e.g. their attachments or relationships).

The anorexic's struggle with autonomy and control over the self parallels the drive for self-sufficiency found in persons with dismissive-avoidant attachment. "As the anorexic deprives herself of food and objects, she

feels omnipotent, in control and unthreatened by death. She triumphantly projects into her external world of objects that they have nothing she desires nor needs in order to exist, and that internally she has all she needs to survive. Hence, she maintains the delusion that she does not need, that she is self-sufficient and that she is independent of her object. ‘In phantasy, ‘no needs’ means no separation, for being entirely self-sufficient prevents any awareness of dependency needs in relation to the self. If desire does not exist, mother unconsciously need not exist. The connection of both birth and early nurturing and dependence can be denied. By starving it need never be known.’ Furthermore, it seems that she desperately attempts to barricade any object from entering her ‘ideal’ internal world. With this said, it appears that, unconsciously, she is punishing the external objects for being unable to meet her needs as they watch her fade away.” See Gilhar.

I wonder if the following observations found in another paper on anorexia offer hints about my obsession with my former primary care doctor, Dr. P. as an idealized “mirror image” object. Gaynor writes: “The anorexic refuses the symbolic dependency which ties her to the signifiers of the Other. She wishes to have her own independence and become separate from every object. She is unwilling to be regulated by the jouissance of the drive. The subject no longer wishes to be swallowed up by the desire of the Other. Through anorexia she can introduce a separating element between herself and the abusive jouissance of the Other. ‘*The only Other that matters to her is the Other of the reflected mirror image, the Imaginary Other, the idealized similar one, the Other as an ideal projection of her own body elevated to the dignity of an icon, the Other as a reflected embodiment of the Ideal Ego, as a narcissistic double of the subject, the idealized Other of the reflected image of the thin body.*’ The anorexic protests against being subjected to the signifiers of the Other. She does not wish to be subject to the desire of the Other. Dependency [as in dismissive avoidant attachment] is to be avoided at all costs as the anorexic strives for mastery and to be separated from the demand of the mother (emphasis

added)." "*If I have an idealized similar one (twin), I will not need the object, food.*"

Are these observations related to Stanley Coen's ideas about twin transference? Coen writes that twin transference, together with all twin fantasies, subserves multiple functions, particularly gratification and defense against the dangers of intense object need. In this formulation, the twinlike representation of the object provides the illusion of influence or control over the object by the pretense of being able to impersonate or transform oneself into the object and the object into the self. Intense object need persists together with a partial narcissistic defense against full acknowledgment of the object by representing the sought-after object as combining aspects of self and other. Coen, S.J. and Bradlow, P., "Twin Transference as a Compromise Formation." "*If I had a twin, it would extinguish my need for a true other.*"

Then too, are these observations related to Kohut's case of Mr. U who defended against fear of engulfment by mother (who has a breast) by his idealization of a distant but desired and disappointing father? Kohut's patient Mr. U who, turning away from the unreliable empathy of his mother, tried to gain confirmation of his self through an idealizing relationship with his father. The self-absorbed father, however, unable to respond appropriately, rebuffed his son's attempt to be close to him, depriving him of the needed merger with the idealized self-object and, hence, of the opportunity for gradually recognizing the self-object's shortcomings. Cowan, "Self and Sexuality." "*If I had father, I wouldn't need mother (who has a breast).*" Notably, Mr. U's dilemma parallels the recognized dynamics found to prevail in the anorexic's relationship with both parents: "Several clinical investigators consider that the father is experienced by his anorexic daughter as minimally involved, inadequately responsive to her, and unable to foster her autonomy by providing 'a benevolent disruption of the mother-child symbiosis.' He is unable to

facilitate the daughter's sense of being special and lovable." Bers, S.A., et al., "An Empirical Exploration of the Dynamics of Anorexia Nervosa: Representations of Self, Mother, and Father."

Might my defenses against object need help explain the problem of scapegoating I experience in groups? Kernberg writes: "The psychology of the group, then, reflects three sets of shared illusions: (1) that the group is composed of individuals who are all equal, thus denying sexual differences and castration anxiety; (2) that the group is self-engendered – that is, as a powerful mother of itself; and (3) that the group itself can repair all narcissistic lesions *because it becomes an "idealized breast mother."*" Kernberg, O.F. "Ideology, Conflict, and Leadership in Groups and Organizations (emphasis added)."

In group situations I seem to want symbolically to avoid being fed by the "idealized breast mother" at any cost. I do not participate in group process; that is to say, I do not share unconscious feelings and fantasies with the group. I will thereby be an outsider in groups, and, as an outsider, I set myself up for attack by group members, who view me as an alien threat to group cohesion. "*If I remain independent, I won't need the group (breast mother).*" I note that one author sees interesting links between attachment theory – specifically, the infant's secure attachment to mother – and the profound sense of belonging inherent in group membership. Montgomery, C., "Role of Dynamic Group Therapy in Psychiatry."

And because of depressive anxiety I get a psychological gratification from being attacked by the hated group. Elliott Jaques describes the psychodynamics of the complex interplay that can prevail between a persecuting (paranoid) majority group and a minority group struggling with depressive anxiety.

Jaques writes: "Let us consider now certain aspects of the problem of the scapegoating of a minority group. As seen from the viewpoint of the community at large, the community is split into a good majority group and a bad minority—a split consistent with the splitting of internal objects into good and bad, and the creation of a good and bad internal world. The persecuting group's belief in its own good is preserved by heaping contempt upon and attacking the scapegoated group. The internal splitting mechanisms and preservation of the internal good objects of individuals, and the attack upon and contempt for internal bad persecutory objects, are reinforced by introjective identification of individuals with other members taking part in the group-sanctioned attack upon the scapegoat. If we now turn to the minority groups, we may ask why only some minorities are selected for persecution while others are not. Here a feature often overlooked in consideration of minority problems may be of help. The members of the persecuted minority commonly entertain a precise and defined hatred and contempt for their persecutors which matches in intensity the contempt and aggression to which they themselves are subjected. That this should be so is perhaps not surprising. But in view of the selective factor in choice of persecuted minorities, must we not consider the possibility that one of the operative factors in this selection is the consensus in the minority group, at the phantasy level, to seek contempt and suffering. That is to say, there is an unconscious co-operation (or collusion) at the phantasy level between persecutor and persecuted. For the members of the minority group [struggling with depressive anxiety], such a collusion carries its own gains—such as social justification for feelings of contempt and hatred for an external persecutor, with consequent alleviation of guilt and reinforcement of denial in the protection of internal good objects (emphasis added)." Jaques, E. "On the Dynamics of Social Structure – A Contribution to the Psychoanalytical Study of Social Phenomena Deriving from the Views of Melanie Klein."

Psychological Test Results

Psychological Test Results

Psychological Evaluation

Confidential

Name: Gary Freedman

Dates of Evaluation: 2/24/2014

Date of Birth: 12/23/1953

Age: 60

Evaluator: David Angelich, Psy.D.

Reason for Referral:

Mr. Freedman sought a psychological evaluation in order to obtain more information about a diagnosis for himself. Mr. Freedman was evaluated in 1994 at George Washington University, but he did not receive a diagnosis from this assessment. He is currently seeking more specific information regarding a possible personality disorder diagnosis. Overall, this evaluation is thus requested to provide more information about Mr. Freedman's emotional functioning to clarify treatment planning.

Assessment Measures:

Millon Clinical Multiaxial Inventory - 3rd Edition (MCMI-III)

Minnesota Multiphasic Personality Inventory - 2nd Edition (MMPI-2)

Clinical Interview with Mr. Freedman

Consultation with Mr. Freedman's psychiatrist

Relevant Background Information:

Family Background. Mr. Freedman is the younger of two children. He has an older sister who is six years his senior. Mr. Freedman described a difficult and traumatic childhood. Mr. Freedman's father was physically

abusive toward him beginning at an early age. Mr. Freedman's father was also physically abusive towards Mr. Freedman's mother, attempting to strangle her to death at one time during Mr. Freedman's childhood. Mr. Freedman described poor, abusive background of his mother as well. Mr. Freedman reported that he felt more intense anger at his mother for not protecting him from his father's abuse, as opposed to conscious anger at his father. Mr. Freedman's parents have both been deceased since Mr. Freedman was in his 20's. Mr. Freedman reported that he recalled feeling very little emotional responses when his mother passed away.

Relationship History. Mr. Freedman has been in one romantic relationship with a woman, which occurred when he was in his twenties. This relationship ended due to the woman's insistence on marriage, which did not interest Mr. Freedman. This relationship lasted for one year. Mr. Freedman described little interest in pursuing a romantic relationship at the current time.

Educational/ Work History. Mr. Freedman is a Penn State graduate for his journalism degree, and he has Law Degree from Temple University. He received a Master of Laws from American University as well. During High School Mr. Freedman had few friends and ended one friendship due to the intense shame he felt about the abuse he suffered in his home growing up.

Mr. Freedman worked at the Franklin Institute beginning at the age of 16. He did editorial work and also managed a scientific publication at one time. Following his Master of Laws Degree, Mr. Freedman worked at a Law Firm doing legal research for approximately three and a half years. This job ended after Mr. Freedman described being overlooked for promotions despite earning high marks on his reviews. Mr. Freedman discussed feeling that he was being treated unfairly at the firm with fellow employees spreading rumors about him to damage his reputation. Mr. Freedman's employment with this law firm ended, and Mr. Freedman did

not return to work. He qualified for disability benefits at this time due to a mental health diagnosis. Medical History. Mr. Freedman had scarlet fever as a young child. He also had an accident as a young child, where he fell with a curtain rod hitting him in his mouth resulting in significant bleeding.

Psychiatric History/ Previous Treatment. Mr. Freedman described wanting to see a psychiatrist since High School, but his parents would not permit this. In 1990, he began seeing a psychiatrist to work on family related problems. This treatment lasted for one year. In 1991, a psychologist treated Mr. Freedman for 20 weeks for hypnotherapy, but he was ultimately deemed not able to be hypnotized. In 1992, Mr. Freedman began treatments with psychiatric residents at George Washington University. Mr. Freedman reported that he did not want to take medication at this time. In 1999, Mr. Freedman began taking medication in the form anti-depressants. In 2001, he began taking Zyprexa which he stated was not helpful. Mr. Freedman attempted suicide in 1977 by overdose (age 23). He was found unconscious while living with his mother. He was not hospitalized at this time. Mr. Freedman has not been hospitalized for psychiatric problems.

Behavioral Observations/ Mental Status:

Mr. Freedman is a 60-year-old male of average stature who appears in good health. On the date of his evaluation he was dressed casually and appropriately. His thought processes were coherent, intact and goal directed. Mr. Freedman's affect was somewhat flat. His mood appeared to be mildly depressed and anxious at times, but stable. He did not complain of depression. Mr. Freedman appeared somewhat anxious about the testing, but he gave good effort. Mr. Freedman was cooperative with voicing his thoughts through the interview and testing process. His judgment appeared poor to fair based on his interview process with this evaluator. Testing results are felt to represent an accurate estimate of his

current emotional functioning.

Emotional/ Personality Functioning:

The MCMI-III and the MMPI-2 were given to assess Mr. Freedman's personality and emotional functioning. The MCMI-III and MMPI-2 are structured personality measures that was administered to Mr. Freedman to determine the extent to which he may be experiencing psychiatric symptoms in addition to finding out more about his general personality make-up. Mr. Freedman's profiles on the MCMI-III and MMPI-2 are consistent with his current presentation and congruent with his history. Test results are considered to represent a valid measure of his personality and current mental state. The MCMI-III reports T Scores for the clinical measures and scales. A T score of 65 or above is considered statistically significant. On the Severe Clinical Syndromes Scales, Mr. Freedman obtained a T Score of 72 on the Delusional Disorder Scale. On the Severe Clinical Personality Patterns Scales, Mr. Freedman's test profile revealed a T-Score of 67 on the Schizotypal Personality Pattern Scale. On the Clinical Personality Patterns Scales, he obtained a T Score of 105 in the Narcissistic Scale. Also in the Clinical Personality Patterns Scales, Mr. Freedman obtained a T- Scores of 65 and above (considered statistically significant) on the following scales: T Score of 85 in the Schizoid Scale, 78 on the Avoidant Scale and a T Score of 76 on the Depressive Scale.

Mr. Freedman's MMPI-2 clinical scales showed elevations on 4 overall scales: the Psychopathic Deviate Scale #4 with a T Score of 69, the Paranoia Scale #6 with a T score of 83, the Social Introversion Scale #0 with a T Score of 71, and the Masculinity- Femininity Scale #5 with a T Score of 76. T scores are considered statistically significant if they are 65 or above. The two tiered personality code types are the most solidly supported by research. When a subject has several elevated clinical scales, the most salient features of each personality code type are used to describe the test subject. Mr. Freedman's elevated Clinical Scales correspond

primarily to the 4-6/ 6-4 personality code types. Persons with the 4-6/ 6-4 code type are immature, narcissistic, and self-indulgent. They are passive-dependent individuals who make excessive demands on others for attention and sympathy, but they are resentful of even the mildest demands made on them by others. They do not get along well with others in social situations, and they are especially uncomfortable around members of the opposite sex. They are suspicious of the motivations of others and avoid deep emotional involvement. They generally have poor work histories and marital problems are quite common. They appear to be irritable, sullen, and argumentative. They seem to be especially resentful of authority and may derogate authority figures.

Individuals with the 4-6/ 6-4 code type tend to deny serious psychological problems. They rationalize and transfer blame to others, accepting little or no responsibility for their own behavior. They are somewhat grandiose and unrealistic in their self-appraisals. Because they deny serious emotional problems, they generally are not receptive to traditional professional counseling or therapy. In general, as the elevations of scales 4 and 6 increases and as scale 6 becomes higher than scale 4, a pre-psychotic or psychotic disorders becomes more likely. They present with vague emotional and physical complaints. They report feeling nervous and depressed, and they are indecisive and insecure.

Overall testing results support the diagnosis of a Delusional Disorder persecutory type along Axis I. It is noted that Mr. Freedman was administered the Wisconsin Card Sorting Test at The George University Medical School in March 1996 and achieved a perfect score (6 errors). As noted in this previous 1996 evaluation, the reader is reminded that Mr. Freedman's delusions are without prominent mood symptoms, auditory hallucinations or a formal thought disorder. Mr. Freedman also did not report symptoms of mania as demonstrated by his T score of 36 on Scale 9 (Mania). Mr. Freedman did earn a T score of 70 on the Social Introversion Scale, Scale 0. On another content measure of Social

Introversion, the SOD Scale, Mr. Freedman earned a T Score of 81. Although diagnosed with Alcoholism in the past, Mr. Freedman did not report significant addiction difficulties in the present evaluation; he earned a T Score of 48 on the MAC-R Scale (Addiction Proneness). Mr. Freedman earned a T score of 43 on the Es content scale (Ego Strength).

Regarding Axis II, and personality disorders, Mr. Freedman has prominent features of several different personality disorders, as noted in his MCMI-III results as well as the MMPI-2 as noted above. It is felt that he can best be described as having a Personality Disorder, NOS with Prominent Narcissistic, Schizoid, and Avoidant Traits with Depressive Personality Features.

Recommendations:

Continued medication management as well as long-term therapy is recommended for Mr. Freedman.

It was truly a pleasure working with Mr. Freedman to complete this evaluation. If you have any questions or need additional information, please do not hesitate to contact Dr. Angelich at (202) 494 6722.

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PERSONAL COMMENTS

The selective test results on which Dr. Angelich's report is based, namely, only two elevated scales of the MMPI, are identical to the psychological test results of Ted Kaczynski, the so-called Unabomber. The problem is that Mr. Kaczynski is a serial killer and a domestic terrorist. I am not a serial killer or a domestic terrorist.

The following text is a brief excerpt from the forensic report filed by psychiatrist Sally Johnson, M.D. in Mr. Kaczynski's criminal prosecution.

The WAIS-R results (IQ) were Verbal Score of 138, Performance Score of 124, and Full Scale Score of 136. People with the 4-6 two-point code pattern (as evident in Mr. Kaczynski's profile with Scale 4=69, Scale 6=68) are described as viewing the world as threatening and feeling misunderstood or mistreated by others. Such people can be hostile, irritable, and demanding. They are commonly very self-centered and are not concerned about the rights of others. Indeed, they are often resentful of the success of other people and suspicious of their motives. In addition, these people can be impulsive and manipulative, frequently getting into conflict with family and authorities. They often have unstable family lives, personal relationships, poor work and educational histories, and legal problems. This profile is associated with stable characteristics and such people are very resistant to treatment interventions.

They often deny that they have problems and are evasive about discussing them, sometimes refusing to talk about personal shortcomings at all. They avoid close relationships and have trouble getting along with those people with whom they do come in contact, including family members. Such people have vague goals and are indecisive about many aspects of their lives.

Similar to the MMPI-2, Mr. Kaczynski's responses to the Millon Clinical Multiaxial Inventory, Second Edition might be described as forthright and self revealing. His pattern of item endorsement does not suggest overt attempts to

exaggerate nor minimize psychological problems, and to the contrary appears to reflect a balance between self-protective and potentially self-effacing responses. The resulting clinical scale profile is viewed as a useful indication of his current personality functioning.

Modest elevations are present on clinical scales: Schizoid (1)=73; Avoidant (2)=71; Sadistic Aggressive (6B) =78. Persons with similar test results typically exhibit difficulties primarily characterized by hostile alienation. These persons often espouse overt disregard for or anger at significant others and other people in general. They may avow few or no attachments to others and deny experiences of either positive sentiments or feelings of guilt or shame. They tend to relate to others primarily through threats or hostile posturing, or overt aggression, but may prefer outright avoidance of social contacts. They are often seen as dogmatic and unyielding, and may espouse unusual social, political or religious ideas. They often view others as devalued and unimportant and may act in ways that others see as cold, unfeeling, or callous. Formal disorder in the flow and form of thought is not generally associated with this pattern of results, and marked sensory disturbances are not typically noted.

Personal Re-interpretation of Psychological Test Raw Data

On the MMPI a T-score of 65 or higher is considered statistically significant.

1. High schizoid score on the MMPI (T Score of 85) (possible inference: unempathic mother). The patient shows a lack of social interest; he is socially detached, with a rich, elaborate, and internal fantasy world. Patient's high schizoid score (T Score of 85) is consistent with social anhedonia, a genuinely asocial trait and not a defensive reaction to social isolation. People high in social anhedonia were more likely to be alone and to prefer solitude. When alone, socially anhedonic people did not attribute their solitude to perceived or expected social rejection; instead, they reported being alone by choice. When with other people, socially anhedonic people reported asocial feelings and took part in larger and less

intimate social groups. Finally, social anhedonia moderated the effect of solitude on positive and negative affect: people high in social anhedonia reported more positive affect and less negative affect when they were alone than when they were with other people. Kwapis, T.R. "The Social World of the Socially Anhedonic: Exploring the Daily Ecology of Asociality." *Journal of Research in Personality* 43: 103-106 (2009).

2. High narcissistic score on the MMPI (T score of 105) (possible inference: mother who failed to mirror child or who used patient to satisfy her own psychological needs). Patient may have an extravagant need for twinship, idealization, and mirroring (Kohut). A speculative inference is warranted. Idealization can be a manic defense against loss (Akhtar); there is a remote possibility the patient is struggling with pathological mourning (see paragraph 4, below). Kieffer identified an "entitled victim" syndrome characterized by significant schizoid traits (T=85) and narcissistic traits (T=105) combined with unconscious mourning (melancholia) (T=76) and a hunger for an idealizing relationship. Kieffer, C. "Restitutive Selfobject Function in the 'Entitled Victim:' A Relational Self-Psychological Perspective."
3. High avoidant score on the MMPI (T score of 78) (possible inference: rejecting mother). Patient is dismissive of the value of relationships. Connors, M.E. "The Renunciation of Love: Dismissive Attachment and its Treatment." *Psychoanalytic Psychology*, 14(4): 475-493 (1997).
4. Patient is depressive (T score of 76).
5. Patient experienced abuse and scapegoating in family of origin (MMPI Family Discord scale, T=65). The MMPI social alienation score of T=71 supports an inference of scapegoating in the family of origin. Gordon, R.M. "Definitions of MMPI/MMPI-2: Basic Scales and Subscales." The PTSD scale was mildly elevated (T=60), though not statistically significant. However, it is not clear whether the MMPI can detect disguised

presentation of complex trauma (Galinas). Note that characterological depression ($T=72$) is a characteristic feature of disguised presentation of complex trauma (Galinas). Patient views relationships as dangerous (MMPI Code type: 4-6) and has a wounded sense of self (MMPI Code type: 4-6), which are characteristics of complex trauma. Tarocchi, A. "Therapeutic Assessment of Complex Trauma: A Single-Case Time-Series Study." *Clin Case Stud.* 12(3): 228-245 (June 2013). The patient's MMPI Code type 4-6 is consistent with abusive parenting: Typically, the parental expectations or rules were enforced quite literally, without consideration or flexibility regarding the needs and distresses of the child. Parental (or other family members') tempers are apt to have been intensely threatening and frightening to the person as a small child. The parents were experienced as punitive and coercive of the child's will and indifferent to the child's distress, and punishments were often severe. Marks, P.A., Seeman, W., and Haller, D.L. *The actuarial use of the MMPI with adolescents and adults.* Baltimore: Williams & Wilkins (1974).

A sense of entitlement can grow out of an abusive family environment. Kramer, S. "A contribution to the concept 'the exception' as a developmental phenomenon." *Child Abuse Negl.* 11(3):367-70 (1987). (See paragraph 2, above: Kieffer has identified an "entitled victim" syndrome that combines schizoid traits ($T=85$), narcissistic traits ($T=105$), and unconscious mourning (melancholia) ($T=76$) with a hunger for an idealizing relationship.). See also, "Mediating Role of Maladaptive Schemas between Childhood Emotional Maltreatment and Psychological Distress among College Students," *Practice in Clinical Psychology*, 3(3): 203-211 (2015) (emotional maltreatment in childhood is etiologic for adult feelings of defectiveness/ shame, vulnerability to harm, self-sacrifice, and entitlement).

a) Patient may experience anxiety and guilt in relation to drive expression, typical of individuals who were subjected to scapegoating and massive projections in the family of origin (Family Discord, $T=65$; Social

Alienation, T=71) (Novick and Kelly). Patient may appear to show a lack of motivation.

- b) Patient may be at risk for revictimization (scapegoating) in groups. Hazell, C. *Imaginary Groups* (Bloomington, Indiana: Authorhouse, 2005). "Certain factors typically make an individual or subgroup a candidate to become a repository for unwanted group parts. Individual history can prime an individual or subgroup to receive a certain type of group projection. Individuals, for example, who have been designated as black sheep in families (Family Discord, T=65; Social Alienation, T=71) may be predisposed to become scapegoats in groups.
- c) As a victim of scapegoating and abuse (Family Discord, T=65; Social Alienation, T=71), patient may have an elusive personality (Shengold). Patient cannot reveal essential aspects of his personality to the therapist. Patient will be criticized as non-disclosive. Jerry M. Wiener, M.D., Psychiatry Department Chair, GW, said to patient in August 1993: "You can't reveal yourself." The patient's lack of significant manifest distress might be consistent with a personality that dreads sadness and that is unable to mourn, i.e., an individual who employs idealization as a manic defense against mourning and loss (see paragraph 2, above). See Goldsmith, R.E. and Freyd, J.J. "Awareness for Emotional Abuse." *Journal of Emotional Abuse*, 5(1): 95-123; 2005 (there is a connection between emotional abuse and difficulty identifying emotions).
- d) As a victim of scapegoating and abuse (Family Discord, T=65; Social Alienation, T=71) patient may have a tendency to massive splitting (a split between observing and experiencing egos) and isolative defenses (a split between thought and feeling) (Shengold). Patient may be unable to express feelings in therapy.
- e) As a family scapegoat (Family Discord, T=65; Social Alienation, T=71) patient might have had a sibling who was idealized by the family of origin

(Everett and Volgy).

f) As a victim of scapegoating and abuse (Family Discord, T=65; Social Alienation, T=71) patient may have had a past in which important others were controlling, overly-critical, punitive, judgmental, and intrusive. This type of family background is conducive to the development of introjective (versus anaclitic) personality pathology (Blatt and Schichman).

Individuals with an introjective, self-critical personality style may be more vulnerable to depressive states in response to disruptions in self-definition and personal achievement as opposed to anaclitic concerns centering on libidinal themes of closeness, intimacy, giving and receiving care, love, and sexuality. In anaclitic depression the development of a sense of self is neglected as these individuals are inordinately preoccupied with establishing and maintaining satisfying interpersonal relationships. Introjective depressive states center on feelings of failure and guilt centered on self-worth. Introjective depression is considered more developmentally advanced than anaclitic depression. Anaclitic depression is primarily oral in nature, originating from unmet needs from an omnipotent caretaker (mother); while introjective depression centers on formation of the superego and involves the more developmentally advanced phenomena of guilt and loss of self-esteem during the oedipal stage. Patients with introjective disorders are plagued by feelings of guilt, self-criticism, inferiority, and worthlessness. They tend to be more perfectionistic, duty-bound, and competitive individuals, who often feel like they have to compensate for failing to live up to the perceived expectations of others or inner standards of excellence. What is common among introjective pathologies is the preoccupation with more aggressive themes (as opposed to libidinal) of identity, self-definition, self-worth, and self-control. In the pathologically-introjective, development of satisfying interpersonal relationships is neglected as these individuals are inordinately preoccupied with establishing an acceptable identity. The focus is not on sharing affection—of loving and being loved—but rather on

defining the self as an entity separate from and different than another, with a sense of autonomy and control of one's mind and body, and with feelings of self-worth and integrity. The basic wish is to be acknowledged, respected, and admired.

6. Patient has high executive functioning (perfect score on Wisconsin Card Sorting Test):

a) The patient has an unusual ability to ascribe mental states to others; is able to model and understand the internal, subjective worlds of others, making it easier to infer intentions and causes that lay behind observed behaviors; and an unusual ability to judge the emotion in another person's gaze. Decety, J. and Moriguchi, Y. "The Empathic Brain and its Dysfunction in Psychiatric Populations: Implications for Intervention Across Different Clinical Conditions" (describing characteristics associated with high executive functioning).

b) The patient will tend to be viewed as paranoid by others. Patient's MMPI paranoia scale (Scale 6) was high ($T=83$), but this score should be interpreted in light of his WISC perfect score, i.e., his high executive functioning. Indeed, Anastasi points out that an elevated Scale 6 (Paranoia) can indicate paranoia, or, alternatively, a "curious, questioning and investigative personality."

7. The MMPI results suggest a creative personality. MMPI-2 scales with significant correlations to the C (creativity) scale are Scale 4 (psychopathic deviate, $T=69$), Scale 5 (femininity, $T=76$), Scale 9 (not significant; but viewed as psychotically manic by three psychiatrists), and Scale O (social introversion, $T=71$); as well as GF (gender female, $T=57$), MAC-R (admitted addiction scale, $T=65$), ES (ego strength) (perfect score in Wisconsin Card Sorting Test), and SOD (social discomfort, $T=81$). Nassif, C. and Quevillon, R. "Creativity Scale for the MMPI-2: The C Scale."

Patient had a statistically significant score on the schizotypy scale (MMPI, T=67). Schizotypy can be associated with creativity, that is, an adaptive ability to associate ideas in unusual ways. Fink, A. et al. "Creativity and Schizotypy from the Neuroscience Perspective." Schizotypy correlates with social anhedonia. See Kwapil.

The high psychoticism score (MMPI, T=66) combined with high executive functioning (perfect score on the Wisconsin Card Sorting Test) is consistent with high creative potential. Fodor, E. "Subclinical Manifestations of Psychosis-Proneness, Ego Strength, and Creativity" (ego strength appears to combine with psychosis-proneness to favor creative performance).

Creativity has been shown to correlate with the following characteristics: aggression, autonomy (independence), psychological complexity and richness, and ego strength (will); creative persons' goal is found to be "some inner artistic standard of excellence." Patient may have difficulties in groups that place a premium on abasement, affiliation, and deference (socialization); groups whose goal is to meet the standard of the group (MacKinnon).

Patient also had expansive, detailed, and unusual responses on the Rorschach; he completed the Rorschach protocol then repeated the protocol with the cards turned upside down. That is, the patient completed the Rorschach protocol twice. See Myden, W. "An Interpretation and Evaluation of Certain Personality Characteristics Involved in Creative Production." In: A Rorschach Reader at 165-65. Edited by M.H. Sherman. (New York: International Universities Press, 1960). Myden found the following characteristics in persons with expansive, detailed and unusual responses on the Rorschach:

- Subject has a sense of psychological role in life, a concept that denotes

inner tendencies, deeply embedded in the personality of subject, not easily modified, which determine nearly all meaningful relationships. This does not mean that it is not possible for subject to act in a manner that is inconsistent with that role, but when doing so anxiety will probably result, and consequently impair the degree of efficiency with which his life's problems are handled. Since subject's sense of role in life represents a more or less definite conception of reality and of his role in it, a change from such a basic concept is difficult and unlikely. Subject is apt to be independent of the opinions of others, and is apt to be more original and creative. This requires more intellectual effort than does conformity.

-Subject is apt to investigate the causes of things; hence, while his rate of learning may be slower, its effects are more lasting. (Compare: A high MMPI Scale 6 (Paranoia) can indicate a "curious, questioning and investigative personality.")

-Subject has an ability to create new personalized constructions and the capacity for inner creation and living more within himself than in the outer world. Consequently, subject is apt to put intellect before feeling; that is, his relations with others are not apt to be easy or fluent. Subject is introverted, and has a tendency to drain off energy into grandiosity and obsessional ruminations or into original conceptions.

-Subject has markedly stronger feelings about interpersonal relationships than noncreative persons; subject's interpersonal relations involve greater intensity. Subject has a consequent tendency to withdraw from unpleasant interpersonal situations.

-Subject accepts id drives and fears, and handles them through a strong ego (compare perfect score on the WISC, indicating high executive functioning), which is constantly engaged in reality testing. Subject reaches out for every form of clue in his environment and retains almost every bit of information, which evidently helps to satisfy his need for

intellectual control of his relationships with the outer world. Subject is sensitive to every nuance of reaction from the outer world as it pertains to him.

- a) Creative persons are independent in thought and action. Compare high MMPI Scale 4 (psychopathic deviate).
- b) Creative persons question authority and are fault finders. They regard authority as arbitrary, contingent on continued and demonstrable superiority. When evaluating communications, they separate source from content, judge and reach conclusions based on the information itself, rather than whether the information source was an “authority” or an “expert” (or therapist). Compare high MMPI Scale 4 (psychopathic deviate).
- c) Creative persons have an ability to invest effort in idea production (Parnes).
- d) Creative persons are drawn to unconscious motives and fantasy life (Frank Barron). (Patient may have a deep-seated aversion to CBT).

8. Patient is intellectually gifted (IQ score in top 2%, verbal IQ top 1%).

- a) Studies show a correlation between high IQ and the personality trait called “openness to experience.” Openness to experience is associated with imagination (fantasy), attentiveness to inner feelings, intellectual curiosity, a motivation to engage in self-examination, and a fluid style of consciousness that allows individuals to make novel associations between remotely connected ideas (i.e., free association). (Patient may have a deep seated aversion to CBT).
- b) Giftedness is associated with uncanny intuition. Compare high mentalization ability associated with high executive functioning

(Grobman). See paragraph 6a, above. See also, Park, L.C., et al., "Giftedness and Psychological Abuse in Borderline Personality Disorder: Their Relevance to Genesis and Treatment" (individuals who become borderline frequently have a special talent or gift, namely a potential to be unusually perceptive about the feelings of others, termed "intuitive giftedness").

- c) Giftedness is associated with existential depression. (Compare MMPI Depressive score, T=76).
- d) Giftedness is associated with deep and complex thoughts.
- e) Giftedness is associated with intense curiosity. (Compare paragraph 6b, above. A high MMPI Scale 6 (Paranoia) can indicate a "curious, questioning and investigative personality.")
- f) Giftedness is associated with remarkable memory. Patient's expansive and detailed responses on the Rorschach (he completed the Rorschach protocol twice) suggest a remarkable memory.
- g) Gifted persons are very independent, autonomous – (compare high MMPI Scale 4 (Psychopathic Deviate)) – and less motivated by rewards and praise.
- h) Giftedness can be associated with introversion.
- i) Giftedness can be associated with feeling different, out of step with others, and having a sense of alienation and loneliness.

